	-	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>NO. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		MPLETED
		495401	B. WING			C 01/19/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		71/13/2023
	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD		
				CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E OC	00		
F 000	survey was conducte The facility was in sul CFR Part 483.73, Re Care Facilities. No en	nergency Preparedness d 1/17/23 through 1/19/23. ostantial compliance with 42 quirement for Long-Term mergency preparedness stigated during the survey.	F 00	00		
	survey was conducte Corrections are requi CFR Part 483 Federa requirements. One co	omplaint was investigated 00057095-substantiated Life Safety Code				
F 578 SS=D	at the time of the survice consisted of 30 reside	ntnue Trmnt;FormIte Adv Dir	F 57	78		2/14/23
	discontinue treatment	ht to request, refuse, and/or t, to participate in or refuse rimental research, and to e directive.				
	construed as the righ the provision of medie	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or				
		acility must comply with the d in 42 CFR part 489, irectives).				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					02/06/2023

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.

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/07/202 MAPPROVE D. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING			C 01/19/2023		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON BRID	OGE			001 IRON BRIDGE RD HESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 578	 (i) These requirement inform and provide we residents concerning medical or surgical the resident's option, form (ii) This includes a we facility's policies to im and applicable State (iii) Facilities are permentities to furnish this legally responsible for requirements of this se (iv) If an adult individue time of admission and information or articular has executed an adve may give advance due individual's resident me with State law. (v) The facility is not the provide this information or she is able to rece Follow-up procedures the information to the appropriate time. This REQUIREMENT by: Based on clinical rece formulate an advance and facility document that the facility staff faresidents in the surve formulate an advance The findings include: For Resident #11 (R1 fully review advance and/or the representa 	ts include provisions to ritten information to all adult the right to accept or refuse eatment and, at the mulate an advance directive. ritten description of the applement advance directives law. mitted to contract with other is information but are still or ensuring that the section are met. ual is incapacitated at the d is unable to receive ate whether or not he or she ance directive, the facility rective information to the representative in accordance relieved of its obligation to on to the individual once he ive such information. Is must be in place to provide e individual directly at the T is not met as evidenced cord review, staff interview t review it was determined ailed to provide one of 30 ey sample the opportunity to e directive (1); Resident #11.	F	578	 Social Services reviewed advant directives with Resident #11, she is H own responsible party (RP). Any resident has the potential to affected. 100% audit of all current residents to verify advance directives have been reviewed with the resider or responsible RP with evidence in the medical record. Any variances will be addressed promptly. 	her o be s nt and ne		

Facility ID: VA0402

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STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495401	B. WING		C 01/19/2023		
	ROVIDER OR SUPPLIER	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI		
F 578	R11 was admitted to the most recent MDS annual assessment w reference date) of 12, scored 13 out of 15 o for mental status) ass resident was cognitive decisions. Review of R11's clinic documentation of adw progress notes docur DNR (do not resuscita The comprehensive of documented in part, " has chosen DNR (do Initiated: 02/16/2019Interven status annually, quart needed) Date Initiated On 1/18/2023 at appr request was made to member) #1, the adm review of advanced d On 1/18/2023 at 12:4 conducted with OSM social services. OSM reviewed advance dir quarterly or annual as that they interviewed the code status and a change it. OSM #3 s	the facility on 2/12/2019. On (minimum data set), an vith an ARD (assessment /16/2022, the resident n the BIMS (brief interview sessment, indicating the ely intact for making daily cal record failed to evidence vanced directive review. The mented periodic review of ate) status. care plan for R11 'Resident/Responsible party not resuscitate). Date tions/Tasks:Review code terly and/or PRN (as d: 02/16/2019" roximately 11:50 a.m., a ASM (administrative staff inistrator, for evidence of irective for R11. 9 p.m., an interview was (other staff member) #3, 1 #3 stated that they rectives when they did the ssessments. OSM #3 stated the resident and discussed asked them if they wanted to tated that as far as the ance directives they did not	F 57	 3) The Assistant Director of Nursi designee will educate Social Servic staff on facility policy of ensuring rerights of being informed and formul advance directives with evidence in medical record. Education will be included in new hire orientation. 4) The Social Services Director of designee will audit resident's charts MDS schedule weekly x 4 weeks the monthly x2 months to verify advance directives have been reviewed with resident and or RP. The DON or designee will review the audit findin report to the QAPI committee for fureview and recommendations months. 	ess esident ating in the r s per hen ce the ngs and irther		

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		495401	B. WING			C 01/19/2023		
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON BRID	GE			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		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE COM SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 578	On 1/19/2023 at 8:00 social service initial a for R11. The assessr "DNR" The sectio "Advanced directives observed to be blank." On 1/19/2023 at appr up interview was con- services. When aske dated 2/16/2019 for F evidenced that the DN The facility policy, "Ad documented in part, " reviewed at minimum scheduleDifferent ty Living willDurable p Status" On 1/18/2023 at 4:33 staff member) #1, the director of nursing, AS of nursing, ASM #4, ti clinical services and A president of operation concern. No further information (1) Advance directives ar allow you to spell out end-of-life care ahead way to tell your wishe health care profession	a.m., ASM #1 provided a ssessment dated 2/16/2019 nent documented in part, on which documented, have been reviewed" was oximately 9:10 a.m., a follow ducted with OSM #3, social d about the assessment R11, OSM #3 stated that it NR was reviewed. dvance Directives Protocol" Advance directives will be annually according to MDS ypes of advance directives : ower of attorneyCode p.m., ASM (administrative e administrator, ASM #2, the SM #3, the assistant director he regional director of ASM #5, the regional vice as were made aware of the n was presented prior to exit.	F	578	3			

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495401	B. WING _		0	1/19/2023
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO		
TYLER'S	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 578 F 580 SS=D	want if you are dying unconscious. You car care. You might want The use of dialysis ar you want to be resusc heartbeat stops. Tub donation. A durable p care is a document th proxy. Your proxy is s health decisions for y so. This information website: https://medlineplus.go Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notifio (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making noti	or permanently n accept or refuse medical to include instructions on: ad breathing machines. If citated if your breathing or e feeding. Organ or tissue power of attorney for health at names your health care omeone you trust to make ou if you are unable to do was obtained from the ov/advancedirectives.html jury/Decline/Room, etc.))(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident as the potential for requiring u; ge in the resident which as the potential for requiring u; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial eatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the		578		2/14/23

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D HUMAN SERVICES IEDICAID SERVICES			PRINTED: 02/07/2023 FORM APPROVED OMB NO. 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
495401	B. WING		C 01/19/2023	
		STREET ADDRESS, CITY, STATE, ZIP CODE		
E		12001 IRON BRIDGE RD CHESTER, VA 23831		
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
5 n specified in §483.15(c)(2) ed upon request to the so promptly notify the ent representative, if any, or roommate assignment O(e)(6); or nt rights under Federal or s as specified in paragraph ecord and periodically ailing and email) and esident site distinct part. A facility tinct part (as defined in in its admission agreement on, including the various e the composite distinct the policies that apply to n its different locations is not met as evidenced ew, facility document review, and in the course of on, it was determined the otify the physician when dications were not f 30 residents in the survey B (R123).	F 5	 Resident #123 no longer re the facility. The nurse caring for #123 that failed to notify the phy antibiotic that was not administe nurse has been be educated on for administering medications ar obtaining medications from on-s medication storage and actions medication not available. Any resident has the potential 	Resident vsician of ered. The protocol nd site to take if	
	All PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495401 E TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL (C IDENTIFYING INFORMATION) 5 n specified in §483.15(c)(2) ed upon request to the so promptly notify the ent representative, if any, or roommate assignment 0(e)(6); or nt rights under Federal or is as specified in paragraph cord and periodically ailing and email) and esident site distinct part. A facility tinct part (as defined in in its admission agreement on, including the various e the composite distinct the policies that apply to n its different locations is not met as evidenced ew, facility document review, and in the course of on, it was determined the tify the physician when ications were not f 30 residents in the survey 8 (R123).	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 495401 B. WING	X1) PROVIDER/SUPPLER/CLIA (X2) MULTIPLE CONSTRUCTION AB5401 B. WING 495401 B. WING E STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831 E PREFIX EMENT OF DEFICIENCIES ID MIST BE PRECEDED BY FULL PREFIX CDENTIFYING INFORMATION) PREFIX 5 n specified in \$443.15(c)(2) ad upon request to the so pormptly notify the int representative, if any, or roommate assignment ((e)(6); or third function paragraph cord and periodically ailing and email) and ssident site distinct part. A facility tinct part (as defined in in its admission agreement on, including the various sit the composite distinct the policies that apply to n its different locations is not met as evidenced w, facility document review, and in the course of on, it was determined the tip tify the physician when ications were not (3 0 residents in the survey 8 (R123). 1) Resident #123 no longer re the facility. The nurse caring for #123 that failed to notify the physician to notify the physician 2) Any resident has the potention of administering medications and obtaining medications for administering medicati	

Event ID: I8OZ11

Facility ID: VA0402

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				PRINTED: 02/07/202 FORM APPROVEI OMB NO. 0938-039
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
	495401	B. WING		C 01/19/2023
ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE COMPLETION
Continued From page	e 6	F 58	0	
medications for chole per the physician orde	sterol were not administered er for R123.		administration for past 7 days w completed to verify medications	
assessment, a Medic with an assessment r the resident scored a interview for mental s resident was severely decisions. In Section resident was coded a and antibiotics during The physician orders documented the follow Lipitor (Atorvastatin) (cholesterol) (1) 80 mg by mouth at bedtime	are five-day assessment, eference date of 9/8/2022, "7" on the BIMS (brief tatus) score, indicating the / impaired for making daily N - Medications the s receiving antidepressants the look back period. dated 8/17/2022, wing: (used to treat high g (milligrams); give 1 tablet for cholesterol.		 3) The Director of Nursing (DC designee will educate 100% nur their responsibility in ensuring m are administered per MD/NP or protocol for obtaining medication on-site storage and notification ti f medication not available. Educ be included in new hire orientati 4) The DON or designee will a medication administration during Morning meeting weekly x 4 we monthly x 2 months to verify me have been administered per MD 	rses on nedications ders and ns from to MD/NP cation will on. audit g Clinical eks then dications
(2) 7.5 mg; give 1 tab Adult Failure to Thrive Sertraline HCL (hydro depression and anxie 150 mg; give 1 capsu related to anxiety disc Ceftriaxone Sodium S (grams) (used to treat milligrams intravenou abscess of liver for 23 The August 2022 MA record) documented to On 8/17/2022, the Lip Sertraline were scheo 9:00 p.m. The nurse of block where it is docu	Iet by mouth at bedtime for e. bochloride) (used to treat by disorders) (3) Capsule by mouth at bedtime order. Solution Reconstituted 2 GM t infections) (4), Use 2000 usly every 24 hours related to 3 days. R (medication administration the above orders. bitor, Mirtazapine and duled to be administered at documented a "19" on the umented as administered. A		The DON or designee will review findings and report to the QAPI	w the audit committee
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RETREAT AT IRON BRID SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page medications for chole per the physician ord On the most recent M assessment, a Medic with an assessment r the resident scored a interview for mental s resident was severely decisions. In Section resident was coded a and antibiotics during The physician orders documented the follor Lipitor (Atorvastatin)) cholesterol) (1) 80 mg by mouth at bedtime Mirtazapine (Remero (2) 7.5 mg; give 1 tab Adult Failure to Thrive Sertraline HCL (hydro depression and anxie 150 mg; give 1 capsur related to anxiety disc (grams) (used to treat milligrams intravenou abscess of liver for 23 The August 2022 MA record) documented to On 8/17/2022, the Lip Sertraline were schere 9:00 p.m. The nurse of block where it is docu- "19" indicated, "Other	CORRECTION IDENTIFICATION NUMBER: 495401 RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	S FOR MEDICARE & MEDICAID SERVICES SF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIP A. BUILDING ROVIDER OR SUPPLIER 495401 B. WING	S FOR MEDICARE & MEDICAID SERVICES 0F DEFICIENCIES (X) PROVIDERSUPPLIERCUA 1DENTIFICATION NUMBER: A BUILDING 4 95401 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE TOUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RETREAT AT IRON BRIDGE STREET ADDRESS, CITY, STATE, ZIP CODE CONTERN FUNCTION NUMBER RETREAT AT IRON BRIDGE On the OFFICIENCY MUST BE PRECIDED BY FULL. Continued From page 6 medications for cholesterol were not administered per MD/NP or designee will addressed. On the most recent MDS (minimum data set) assessment, a Medicate from making daily decisions. In Section 1- Nedications the resident was coded as receiving antidepressants and antibiotics during the look back period. The physician orders dated 8/17/2022, documented the following: Lipitor, Milligrams); giv

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM APPROV IB NO. 0938-03	/ED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495401	B. WING				C 01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON BRID	GE	12001 IRON BRIDGE RD CHESTER, VA 23831					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE	(X5) COMPLETIC DATE	ЛС
F 580	for Ceftriaxone with a There was no schedu administration of the i the nurse documente it is documented as a indicated, "Other/See The EMAR (electronic record) note dated 8// documented for all the Mirtazapine, "Awaiting dated 8/17/2022, for t documented, "Just ac R123 was readmitted The physician orders Lipitor 80 mg; give 1 t for cholesterol Sertraline HCL capsu by mouth at bedtime i Flagyl (metronidazole treat infections) (5), G 8 hours related to abs The September 2022 above orders. The Lip scheduled to be admi 9/2/2022. The nurse of block where it is docu "19" indicated, "Other Flagyl was scheduled 9/3/2022 at 12:00 a.m "19" on the block whe administered.	scheduled time of "24h." led time for the medication. On 8/17/2022, d a "19" on the block where dministered. A "19" Nurses Notes." c medication administration 17/2022 at 8:45 p.m. e Lipitor, Sertraline and g delivery." The EMAR note the Ceftriaxone at 7:36 p.m. dmitted." to the facility on 9/2/2022. documented: tablet by mouth at bedtime le 150 mg; give 1 capsule related to anxiety disorder. e) Tablet 500 mg (used to Give 1 tablet my mouth every scess of liver for 23 days. MAR documented the bitor and Sertraline were nistered at 9:00 p.m. on documented a "19" on the mented as administered. A //See Nurses Notes." The to be administered on the nurse documented a are it is documented as d 9/2/2022 at 8:28 p.m.	F	580				

Facility ID: VA0402

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		ID HUMAN SERVICES				FORI	M APPROVED		
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COMF	PLETED		
		495401	B. WING				C / 19/2023		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		15/2025		
		o		12001 IRON BRIDGE RD					
I YLER'S I	RETREAT AT IRON BRID	GE			CHESTER, VA 23831				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			BE	(X5) COMPLETION DATE				
F 580	Continued From page	<u> </u>	F	58	0				
1 000	"Awaiting delivery."	,0	F F	50					
		are plan dated 8/18/2022,							
	documented in part, "	Resident has altered Interventions" documented							
		edications as directed by							
		are plan further documented							
		lent is on antianxiety therapy							
		order." The "Interventions" Administer antianxiety							
	-	ribed by the physician." The							
	care plan further docu	umented in part, "Resident							
		scess, PICC line." The							
		nented in part, "Administer er physician order and							
	monitor side effect."	or physiolan order and							
		cy pharmacy dispensing							
	machine inventory list								
	following was docume pharmacy machine of								
		blets - PAR level is 10							
	tablets. Mirtazapine 7.5 mg ta	ablets - PAR level is 10							
	tablets.								
	Sertraline 100 mg tab	lets - PAR level is 10							
	tablets.	ata DAD loval in 10 tablata							
	-	ets - PAR level is 10 tablets. g tablets - PAR level is 10							
	tablets.								
	Ceftriaxone 1 GM via	l 1 EA (each) - PAR level - 5.							
	An interview was con	ducted with LPN (licensed							
		he nurse that didn't give the							
		n 9/2/2022, on 1/19/2023 at							
		d the process when a new							
		t it's time for the resident to ons, LPN #4 stated you look							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/07/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495401	B. WING		_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE		2001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	have the medication y pharmacy dispensing the medications are in doctor and follow theil the responsible party, above actions are doo should be in a nurse's program). The above with LPN #4. When at would be in the dispe- stated, they are norm the machine. An interview was con- (administrative staff in nursing, on 1/19/2023) the process for a new ASM #2 stated, if the delivered by the pharm to the (name of pharm and get which ones at are not in the (name of machine) the nurse in see what steps they v available or maybe gi available, then the nu party to inform them v taken. When asked v documented, ASM #2 nurse's note. A request for a policy when medications we requested on 1/19/20 a.m. The facility state	y the medication, if you don't you go to the (name of machine. LPN #4 stated if ot in there, you call the r instructions and then notify When asked where the cumented, LPN #4 stated it is note in (name of computer medications were reviewed sked if these medications nsing machine, LPN #4 al medications, they are in ducted with ASM nember) #2, the director of a t 9:36 a.m. When asked r admission's medications, medications have not been macy yet, the nurse is to go nacy dispensing machine) he can. If the medications of pharmacy dispensing nust call the physician and want to take, hold till ve a substitute that is rse calls the responsible what actions they have where is all this t stated it should be in a for notifying the physician re not available was 23 at approximately 10:15 d they had no policy on n when medications were	F 580				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/07/2023 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COMF	(3) DATE SURVEY COMPLETED	
		495401	B. WING			C 01/19/2023		
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S F	RETREAT AT IRON BRID	GE			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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 580	the medications are a the times ordered, w and check the drugs t if medications are not physician must be not ASM #1, the administ made aware of the ab a.m. No further information (1) This information w following website: https://medlineplus.go tml (3) This information w following website: https://medlineplus.go tml (3) This information w following website: https://medlineplus.go tml (4) This information w following website: https://medlineplus.go tml (5) This information w following website: https://medlineplus.go tml (5) This information w following website: https://medlineplus.go tml (5) This information w following website: https://medlineplus.go tml (5) This information w following website: https://medlineplus.go ml. (6) Lippincott Handbo Bethlehem Pa 2008 p	valiable for administration at erify the physician's order to be sure they are correct given for any reason the tified" (6). rator, and ASM #2, were bove on 1/19/2023 at 9:49 in was obtained prior to exit. ras obtained from the bov/druginfo/meds/a600045.h ras obtained from the bov/druginfo/meds/a697009.h ras obtained from the bov/druginfo/meds/a697048.h ras obtained from the bov/druginfo/meds/a685032.h ras obtained from the bov/druginfo/meds/a685032.h ras obtained from the bov/druginfo/meds/a689011.ht ras obtained from the bov/druginfo/meds/a689011.ht ras of Nursing Procedures rage 569-570.		580				
F 622 SS=D	Transfer and Discharg CFR(s): 483.15(c)(1)(F	622	2		2/14/23	

Event ID: I8OZ11

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495401	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TYLER'S	RETREAT AT IRON BRID	GE			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 622	Continued From page	e 11	F	622			
	 (A) The transfer or dis resident's welfare and cannot be met in the fill (B) The transfer or dis because the resident' sufficiently so the resis services provided by (C) The safety of indirend endangered due to the status of the resident; (D) The health of indirend otherwise be endange (E) The resident has appropriate notice, to under Medicare or Medicare Nonpayment applies submit the necessary payment or after the to Medicare or Medicaid resident refuses to par resident who become admission to a facility resident only allowable or (F) The facility may no resident while the app § 431.230 of this chall exercises his or her ri- discharge notice from 431.220(a)(3) of this challes 	requirements- ermit each resident to and not transfer or t from the facility unless- scharge is necessary for the t he resident's needs facility; scharge is appropriate s health has improved dent no longer needs the the facility; 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 hird party, including d, denies the claim and the ty for his or her stay. For a s eligible for Medicaid after , the facility may charge a te charges under Medicaid; s to operate. ot transfer or discharge the beal is pending, pursuant to					

Facility ID: VA0402

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495401	B. WING				(19/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TYLER'S	RETREAT AT IRON BRID	GE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE			
F 622	or safety of the resider facility. The facility m that failure to transfer §483.15(c)(2) Docum When the facility trans resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum medical record and ap communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the t (i) of this section. (B) In the case of para section, the specific re be met, facility attemp needs, and the servic facility to meet the nee (ii) The documentation (2)(i) of this section m (A) The resident's phy discharge is necessar (A) or (B) of this section (B) A physician when necessary under para this section. (iii) Information provid must include a minim (A) Contact informatio responsible for the ca (B) Resident represent contact information (C) Advance Directive	ent or other individuals in the ust document the danger or discharge would pose. entation. sfers or discharges a the circumstances specified 0(A) through (F) of this ust ensure that the transfer nented in the resident's opropriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot ots to meet the resident e available at the receiving ed(s). n required by paragraph (c) ust be made by- visician when transfer or ry under paragraph (c) (1) on; and transfer or discharge is tograph (c)(1)(i)(C) or (D) of ued to the receiving provider um of the following: on of the practitioner re of the resident. native information including	F	622	2		

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			PRINTED: 02/07/2023 FORM APPROVED OMB NO. 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
495401	B. WING		C 01/19/2023	
		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
0F		12001 IRON BRIDGE RD		
GE		CHESTER, VA 23831		
SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				
are plan goals; ry information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ansition of care. is not met as evidenced ew, clinical record review, review, it was determined iled to evidence that all on was provided to the ospital transfers for three of rvey sample; Residents #1, the facility staff failed to by, required documentation eceiving facility upon a 2/8/22. I record was conducted for th #1 was transferred to the 2/8/22 for further evaluation ontrolled abdominal pain. clinical record failed to hat the required rovided to the receiving M an interview was #2 (Administrative Staff of Nursing. She stated that	F 62	 The Nurse who transferred Reside #1 to hospital is no longer employed. Thurses who transferred Residents #8 a #72 will be educated on the facility polition information/documents required to the sent to receiving facility. Any resident has the potential to be affected. A 100% audit will be complete for all transfer/discharges in the past 7 days to verify required paperwork/documents were sent with them to hospital and or to the responsiliparty; any variances will be addressed warranted. The Director of Nursing (DON)or designee will educate RN's/LPN's on th facility policy for required documentation and paperwork to be sent to the receiving facility. Education will be included in net hire orientation. The Director of Nursing or designee will audit all transfers/discharges week 4 weeks then monthly x 2 months to vee that receiving documents/paperwork has been sent to the receiving hospital, responsible party and Ombudsmen. The 	The nd cy be constant of the nd cy be constant of the ne constant of t	
	IDENTIFICATION NUMBER: 495401 GE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 495401 B. WING	MEDICAID SERVICES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 495401 B. WING GE STREET ADDRESS, CITY, STATE, ZIP CODE 12001 ROM BRIDGE RD CHESTER, VA 23831 Image: Construction of the SPLOAD OF CORRECTION CROSS-REFERENCED TO THE APPROPRIA CROSS-REFERENCE TO THE APPROPRIA (EACH CORRECTIVE ACTION SHOLD B SC IDENTIFYING INFORMATION) 113 F 622 1201 registrate. are plan goals; ry information, including a discharge summary, 211(c)(2) as applicable, and ion, as applicable, to ensure ansition of care. is not met as evidenced 1) The Nurse who transferred Residents #8 a #72 will be educated on the facility poil on information/documents required to the sent to receiving facility. 2) Any resident has the potential to paperwork/documentation aceiving facility upon a 2/8/2/2. 2) Any resident has the potential to b affected. A 100% audit will be complete for all transfer/discharges in the past 7 days to verify required paperwork/documentation aceiving facility upon a 2/8/2/2. 1 record was conducted for nt #1 was transferred to the 2/8/2/2. 3) The Director of Nursing (DON)or designee will educate RN's/LPN's on th facility. Foly or the receiving hat the required rovided to the receiving 4) The Director of Nursing or designe will audit all transfers/discharges weeki 4 weeks then monthy x 2 monts to w that receiving documents/paperwork ka been sent to the receiving hospital,	

Facility ID: VA0402

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/07/2023 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING				C / 19/2023
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TYI FR'S	RETREAT AT IRON BRID	GE		1:	2001 IRON BRIDGE RD		
				С	HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 622	Continued From page	e 14	F	622			
	On 1/19/23 at 10:00 / conducted with LPN a Nurse). She stated th the facility sends the the facesheet, the tra the medication list, a Resuscitate form (if a lab results. She state be documented in the that a copy should be manager's box. A review of the facility that was provided, wa documented, "6. Inf Provider. Information provider must include a. Contact information responsible for the ca Resident representat contact information. information. d. All sp precautions for ongoi Comprehensive care necessary information residents discharge s any other documenta ensure a safe and eff On 1/19/23 at approx (the Administrator) ar aware of the findings, provided by the end of 2. For Resident #8, t	AM an interview was #2 (Licensed Practical hat upon a hospital transfer, change of condition note, nsfer form, the care plan, bed hold notice, the Do Not pplicable) and the current ed that what was sent should a nurse's notes. She stated a retained and left in the unit y policy "Discharge Planning" as conducted. This policy formation to the Receiving provided to the receiving e a minimum of the following: n of the practitioner are of the resident. b. ive information including c. Advance Directive ecial instructions or ng care, as appropriate. e. plan goals. f. All other n, including a copy of the summary, as applicable, and tion, as applicable, to fective transition of care." imately 10:30 AM, ASM #1 nd ASM #2 were made . No further information was of the survey. he facility staff failed to ny, required documentation ecciving facility upon a		022	findings and report to the QAPI com for further review and recommendat monthly x 3 months.		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/07/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING				C 19/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	9 15	F	622	2		
	Resident #8. Resider emergency room on 1	I record was conducted for ht #8 was transferred to the 2/17/22 for further lent for possible injury after					
	reveal any evidence t	clinical record failed to hat the required rovided to the receiving					
	Member) the Director	M an interview was #2 (Administrative Staff of Nursing. She stated that e of what documentation					
	the facility sends the of the facesheet, the tra- the medication list, a Resuscitate form (if a lab results. She state be documented in the						
	that was provided, wa documented, "6. Inf Provider. Information provider must include a. Contact information responsible for the ca	re of the resident. b. ve information including					

Facility ID: VA0402

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/07/2023 MAPPROVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495401	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	19/2023
					12001 IRON BRIDGE RD		
TYLER'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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 622	information. d. All sp precautions for ongoin Comprehensive care necessary information residents discharge s any other documental ensure a safe and eff On 1/19/23 at approx (the Administrator) an aware of the findings. provided by the end of 3. For Resident #72 to provide evidence th goals and medication receiving hospital on facility-initiated transfe On the most recent M admission assessment reference date) of 11/ 15 out of 15 on the Bl mental status) assess resident was cognitive decisions. The progress notes for - "11/3/2022 22:10 (10 Resident admitted to - "11/3/2022 13:22 (11 (physician assistant/m noteSent to ER (em hypotension, chest pa breath)" - "11/3/2022 10:54 (10 Note Text: PT (patien hospital] by EMS (em @ 1048 (10:48 a.m.).	ecial instructions or ng care, as appropriate. e. plan goals. f. All other n, including a copy of the ummary, as applicable, and tion, as applicable, to ective transition of care." imately 10:30 AM, ASM #1 of ASM #2 were made No further information was of the survey. (R72), the facility staff failed nat comprehensive care plan list were sent to the 11/3/2022 for a er. IDS (minimum data set), an nt with an ARD (assessment 2/2022, the resident scored IMS (brief interview for sment, indicating the ely intact for making daily or R72 documented in part, 0:10 p.m.) Note Text: [Name of hospital]." :22 p.m.) Physician/PA/NP nurse practitioner) progress	F	622	2		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING _				C 19/2023
NAME OF PF	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S F	RETREAT AT IRON BRID	GE			001 IRON BRIDGE RD HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	9 17	F 6	522			
	reveal evidence that t	clinical record failed to he medication list or care to the receiving facility.					
	to ASM (administrative administrator for evide	a.m., a request was made e staff member) #1, the ence of documents sent to for the facility-initiated for R72.					
	director of nursing pro- documented above da and stated that was a interview was conduct	a.m., ASM #3, the assistant ovided the progress note ated 11/3/2022 10:54 a.m. Il they had. At that time an ted with ASM #3. ASM #3 as was for staff to complete					
	a change in condition those with the resider staff were also support documenting when the	and transfer form and send nt. ASM #3 stated that the sed to write a progress note e resident left the facility,					
	went to, that a bed ho plan, medication list a sent with the resident did not have any docu	orted, which hospital they old notice, facesheet, care and progress notes were . ASM #3 stated that they umentation to show that the on list were sent with R72.					
		2, the director of nursing and t director of nursing were					
F 623 SS=E		n was provided prior to exit. Before Transfer/Discharge (6)(8)	F 6	323			2/14/23
	§483.15(c)(3) Notice	before transfer.					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495401	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE
F 623	Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and mannee facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility ar resident is transferred (ii) Notice must be may before transfer or disc (A) The safety of indiv be endangered under this section; (C) The resident's her allow a more immedia under paragraph (c)(f (D) An immediate tran required by the reside under paragraph (c)(f)	fers or discharges a hust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The boy of the notice to a Office of the State budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or hear this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	623	3		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING				C / 19/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TYLER'S F	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From page	e 19 ts of the notice. The written	F	623			
		ragraph (c)(3) of this section wing:					
	(iii) The location to wh						
	including the name, a and telephone number	e resident's appeal rights, ddress (mailing and email),					
	to obtain an appeal fo						
	telephone number of Long-Term Care Omb						
	and developmental di	γ residents with intellectual sabilities or related g and email address and					
	telephone number of the protection and ad	the agency responsible for vocacy of individuals with lities established under Part					
	C of the Development and Bill of Rights Act codified at 42 U.S.C.	tal Disabilities Assistance of 2000 (Pub. L. 106-402,					
	disorder or related dis	abilities, the mailing and ephone number of the					
	•	ls with a mental disorder Protection and Advocacy uals Act.					
		es to the notice. le notice changes prior to or discharge, the facility					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/07/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495401	B. WING		C 01/19/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
TYLER'S I	RETREAT AT IRON BRID	GE		2001 IRON BRIDGE RD CHESTER, VA 23831	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 623	as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prito to the State Survey A State Long-Term Carr the facility, and the re- well as the plan for the relocation of the reside 483.70(I). This REQUIREMENT by: Based on staff intervand facility document that the facility staff fa of a hospital transfer Representative and/co Ombudsman office for survey sample; Reside The findings include: 1. For Resident #1, the evidence a written not transfer was provided representative and to Ombudsman office for 10/19/22; and failed the notification of a hospital transfer	bients of the notice as soon the updated information in advance of facility closure closure, the individual who is the facility must provide for to the impending closure gency, the Office of the e Ombudsman, residents of esident representatives, as the transfer and adequate dents, as required at § T is not met as evidenced iew, clinical record review, review, it was determined ailed to provide written notice to the Resident or State Long Term Care or four of 30 residents in the dents #1, #8, #35, and #72.	F 623	 The Director of Social Service designee will send written notifica Responsible Party and State Long Care Ombudsman for Residents # regarding transfers to hospital on 10/19/22 and 12/8/22; Resident #3 transfer on 12/17/22; Resident #3 transfer on 10/25/22; Resident #7 transfer on 11/3/22. Any resident has the potentia affected. A 100% audit of resident have been discharged for past 30 will be completed to verify written notification has been provided to the Responsible Party and sent to State Term Care Ombudsmen. The Director of Nursing or de 	tion to g Term #1 8 for 5 for 2 for al to be ts who days the ate Long
	on 12/8/22.	nical record was conducted		will educate Social Services staff requirements for written notification Responsible Party (RP)and State Term Care Ombudsman of discha	on the on to Long

Facility ID: VA0402

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STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION G	OMB NO. ((X3) DATE SU COMPLE	RVEY		
		105.04		G	с			
		495401	B. WING		01/19	/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
TYLER'S	RETREAT AT IRON BRID	GE		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETION DATE		
F 623	Continued From page	e 21	F 6	23				
	for Resident #1. Res the emergency room	ident #1 was transferred to on 10/19/22 for further nent of anemia. The clinical		Education will be included i orientation.	in new hire			
	notification of this hose to the resident's legal	I any evidence that a written spital transfer was provided I representative and to the e Ombudsman office.		 4) The Director of Nursing will audit all transfers/disch. 4 weeks then monthly x 3 m required written notification provided to the Responsible 	arges weekly x nonths to verify has been			
	Resident #1 was tran room on 12/8/22 for f treatment for uncontr	e clinical record revealed insferred to the emergency further evaluation and trolled abdominal pain. The to reveal any evidence that a		State Long Term Care Omb Audit findings will be report committee monthly x 3 for f and recommendations.	oudsman. ed to the QAPI			
	written notification of	this hospital transfer was ent's legal representative.						
	Member) the Director the written notification	#2 (Administrative Staff r of Nursing. She stated that n to the resident's (legal onsible party) was not						
	the social worker. Sh have a written notice	M, an interview was #7 (Other Staff Member), he stated that she did not to the Ombudsman for verlooked but should have						
	that was provided, wa did not include any di	-						
		imately 10:30 AM, ASM #1 nd ASM #2 were made						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING			0	C 1/19/2023
NAME OF P	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TYLER'S I	RETREAT AT IRON BRID	GE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	provided by the end o	No further information was of the survey.	F	623	3		
	evidence that a writte transfer was provided	he facility staff failed to n notification of a hospital l to the resident ospital transfer on 12/17/22.					
	Resident #8. Resident emergency room on a evaluation and treatm a fall. Further review to reveal any evidence	nent for possible injury after of the clinical record failed e that a written notification er was provided to the					
	Member) the Director the written notification	#2 (Administrative Staff of Nursing. She stated that n to the resident's (legal onsible party) was not					
	that was provided, wa did not include any di	-					
	(the Administrator) an	imately 10:30 AM, ASM #1 ad ASM #2 were made . No further information was of the survey.					
		the facility staff failed to n notification of a hospital					

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	FORM APPROVED B NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495401	B. WING				C 01/19/2023
NAME OF P	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	transfer was provided representative for a h A review of the clinical Resident #8. Resider emergency room on evaluation and treatm a fall. Further review reveal any evidence to this hospital transfer of resident's legal represent On 1/19/23 at 9:06 Al conducted with ASM Member) the Director the written notification representative / responsent something that the facility that was provided, wa did not include any di requirement of notifyi representative and St Om 1/19/23 at approx (the Administrator) an aware of the findings. provided by the end of 4. For Resident #72 to provide evidence to transfer was provided representative for a fa 11/3/2022. On the most recent M admission assessment	I to the resident ospital transfer on 10/25/22. Al record was conducted for int #8 was transferred to the 10/25/22 for further nent for possible injury after of the clinical record failed to that a written notification of was provided to the sentative. M, an interview was #2 (Administrative Staff of Nursing. She stated that in to the resident's (legal possible party) was not cility had been doing. v policy "Discharge Planning" as conducted. This policy rection for the regulatory ing, in writing, the resident tate Long Term Care if a hospital transfer. imately 10:30 AM, ASM #1 ad ASM #2 were made No further information was	F	623	3		

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495401	B. WING			0	C 1/19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	15 out of 15 on the Bl mental status) assess resident was cognitive decisions. The progress notes for - "11/3/2022 10:54 (10 Note Text: PT (patient hospital] by EMS (em @ 1048 (10:48 a.m.). Further review of the reveal evidence that was provided to the re representative for a fa 11/3/2022 On 1/19/2023 at 8:33 to ASM (administrativ administrator for evide transfer was provided representative for a fa 11/3/2022. On 1/19/2023 at 9:25 director of nursing pro- documented above da and stated that was a interview was conduct stated that they did not to show that written n provided to R72 and/o facility-initiated transfer stated that nursing ha written notice of disch discussing a new pro- #3 stated that no one providing a written notice	IMS (brief interview for sment, indicating the ely intact for making daily or R72 documented in part, 0:54 a.m.) Nursing note. t) transported to [Name of iergency medical services) " clinical record failed to written notification of transfer esident and/or the acility-initiated transfer on a.m., a request was made e staff member) #1, the ence of written notification of I to R72 and/or the acility-initiated transfer on a.m., ASM #3, the assistant ovided the progress note ated 11/3/2022 10:54 a.m. II they had. At that time an ted with ASM #3. ASM #3 ot have any documentation otification of transfer was or the representative for a er on 11/3/2022. ASM #3	F	623			

Facility ID: VA0402

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	DNSTRUCTION	(X3) DATE SURVE	8-039 Y
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					С	
		495401	B. WING	01/19/2023		
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE		11 IRON BRIDGE RD ESTER, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMP	X5) PLETION ATE
F 623	Continued From page verbal notification.	25	F 623			
		2, the director of nursing and t director of nursing were				
F 656 SS=E	Develop/Implement C	n was provided prior to exit. Comprehensive Care Plan (3)	F 656		2/14/:	23
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that into objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483 (ii) Any services that y under §483.24, §483. provided due to the re under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive mprehensive care plan must <i>g</i> - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record.				

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/07/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495401	B. WING		C 01/19/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
TYLER'S	RETREAT AT IRON BRID	GE		2001 IRON BRIDGE RD CHESTER, VA 23831	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 656	resident's representa (A) The resident's god desired outcomes. (B) The resident's pre- future discharge. Fac- whether the resident's community was asse- local contact agencie entities, for this purper (C) Discharge plans i plan, as appropriate, requirements set forth section. §483.21(b)(3) The se- by the facility, as outh care plan, must- (iii) Be culturally-com This REQUIREMENT by: Based on observation document review, clir the course of a comp determined the facility and/or implement a c five of 30 residents in Residents #123, #23, The findings include: 1. For R123, the facil the comprehensive ca administration of med order. On the most recent M assessment, a Medic with an assessment r the resident scored a	tive(s)- als for admission and eference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the n in paragraph (c) of this rvices provided or arranged ined by the comprehensive petent and trauma-informed. is not met as evidenced n, staff interview, facility nical record review, and in laint investigation, it was y staff failed to develop omprehensive care plan for the survey sample, #1, #21 and #68.	F 656	 Resident #123 no longer reside the facility. The nurse caring for Res #123 has been educated on followin comprehensive care plan. Resident order for skin prep left heel has beer activated by the Unit Manager and h mat is in place on left side of bed wh bed, round conducted to verify place Resident #1's oxygen flowrate has b checked to verify rate is on correct flowrate per physician's orders. Resi #21's fall mats have been put in place verified via rounds. Resident #68 ca plan was revised to include manage of her dialysis fistula. Any resident has the potential to affected. A 100% audit has been conducted to verify fall mats in place oxygen flowrate per physician orders 	aident g #23 n has fall hile in ement. been dent ce and are ment b be c,

Facility ID: VA0402

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
			5.4/140		С
		495401			01/19/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
TYLER'S	RETREAT AT IRON BRID	GE		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 CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 656	Continued From page	<u>ə</u> 27	F 656		
	resident was severely decisions. In Section resident was coded a during the look back p The comprehensive of documented in part, " cardiac status." The " in part, "Administer m the physician." The ca in part, "Focus: Resid related to anxiety disc documented in part, " medications as preso care plan further docu has infection, liver ab "Interventions" docum antibiotics/anti-viral p monitor side effect." The physician orders documented the follor Lipitor (Atorvastatin) cholesterol) (1) 80 mg by mouth at bedtime Mirtazapine (Remero (2) 7.5 mg; give 1 tab Adult Failure to Thrive Sertraline HCL (hydro depression and anxie 150 mg; give 1 capsu related to anxiety disc Ceftriaxone Sodium S	 / impaired for making daily N - Medications the s receiving antidepressants period. care plan dated 8/18/2022, 'Resident has altered Interventions" documented redications as directed by are plan further documented lent is on antianxiety therapy order." The "Interventions" 'Administer antianxiety ribed by the physician." The umented in part, "Resident scess, PICC line." The nented in part, "Administer er physician order and dated 8/17/2022, wing: (used to treat high g (milligrams); give 1 tablet for cholesterol. n) (used to treat depression) ret by mouth at bedtime for e. ochloride) (used to treat ety disorders) (3) Capsule ile by mouth at bedtime 		 management of dialysis site and worprovider weekly assessment recommendations activated and number following care plan. 3) The Director of Nursing or design will educate nursing staff on following physician's orders and care plan interventions to ensuring to fall mats place, 02 flowrate per order, manage of dialysis site, and following wound provider assessment recommendation and orders. Education will be included new hire orientation. 4) The Director of Nursing or design will conduct weekly audits to verify or plan interventions are being followed but not limited to placement of fall m 02 flowrate per order, management of dialysis site, wound provider recommendations and orders x 4 we then monthly x 2 months. The audit findings and report to the QAPI com for further review and recommendation monthly x 3 months. 	ses gnee g in ement ons ed in gnee are d for ats, of eeks mittee

If continuation sheet Page 28 of 78

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		495401	B. WING				C / 19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	· _	
TYLER'S	RETREAT AT IRON BRID	GE			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Lipitor 80 mg; give 1 f for cholesterol Sertraline HCL capsu by mouth at bedtime if Flagyl (metronidazole treat infections) (5), G 8 hours related to abs The August 2022 MA record) documented to On 8/17/2022, the Lip Sertraline were sched 9:00 p.m. The nurse of block where it is docu "19" indicated, "Other August MAR also doc for Ceftriaxone with a There was no schedu administration of the the nurse documente it is documented as a indicated, "Other/See The EMAR (electronic record) note dated 8/ documented for all the Mirtazapine, "Awaiting dated 8/17/2022, for t documented, "Just ac The September 2022 above orders. The Lip scheduled to be admi 9/2/2022. The nurse of block where it is docu "19" indicated, "Other Flagyl was scheduled 9/3/2022 at 12:00 a.m	ablet by mouth at bedtime le 150 mg; give 1 capsule related to anxiety disorder.) Tablet 500 mg (used to Sive 1 tablet my mouth every acess of liver for 23 days. R (medication administration he above orders. otor, Mirtazapine and buled to be administered at documented a "19" on the mented as administered. A /See Nurses Notes." The sumented the above order scheduled time of "24h." led time for the medication. On 8/17/2022, d a "19" on the block where dministered. A "19" Nurses Notes." c medication administration 17/2022 at 8:45 p.m. e Lipitor, Sertraline and g delivery." The EMAR note he Ceftriaxone at 7:36 p.m.	F	650	6		

Facility ID: VA0402

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-						FORM APPROVED MB NO. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(3) DATE SURVEY COMPLETED
	495401	B. WING _				C 01/19/2023
ROVIDER OR SUPPLIER	L		STREET ADDRESS	S, CITY, STATE, ZIP CODE		
RETREAT AT IRON BRID	GE					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH	H CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
administered. The EMAR note dated documented for the S medications, "On order Flagyl, dated 9/3/2022 "Awaiting delivery." The on-site emergence machine inventory list following was docume pharmacy machine or Atorvastatin 40 mg ta tablets. Mirtazapine 7.5 mg ta tablets. Sertraline 100 mg table tablets. Sertraline 50 mg tables Metronidazole 500 mg tablets. Ceftriaxone 1 GM viai On 1/18/2023 at 2:51 conducted with LPN (LPN #3 stated the put to let staff know what resident. LPN #3 stated there to help them tak help to avoid any incide On 1/18/2023 at 3:47 conducted with RN (reference)	d 9/2/2022 at 8:28 p.m. bertraline and Lipitor er." The EMAR note for the 2 at 12:07 a.m. documented, cy pharmacy dispensing t was reviewed. The ented as being in the n site: blets - PAR level is 10 ablets - PAR level is 10 blets - PAR level is 10 ets - PAR level is 10 tablets - PAR level is 10 lets - PAR level is 10 ablets - PAR level is 10 tablets - PAR level is 10 l 1 EA (each) - PAR level - 5. p.m., an interview was licensed practical nurse) #3. rpose of the care plan was was needed to care for the ted that the care plan was ke care of the residents and dents. p.m., an interview was egistered nurse) #3, unit	F 6	56	DEFICIENCY)		
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RETREAT AT IRON BRID SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page administered. The EMAR note date documented for the S medications, "On ord Flagyl, dated 9/3/202 "Awaiting delivery." The on-site emergend machine inventory lis following was docume pharmacy machine or Atorvastatin 40 mg tat tablets. Sertraline 100 mg tat tablets. Sertraline 50 mg table Metronidazole 500 m tablets. Sertraline 50 mg table Metronidazole 500 m tablets. Ceftriaxone 1 GM via On 1/18/2023 at 2:51 conducted with LPN (LPN #3 stated the pu to let staff know what resident. LPN #3 stat there to help them tal- help to avoid any inci On 1/18/2023 at 3:47 conducted with RN (r manager. RN #3 stat care plan was to plan	CORRECTION IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 administered. The EMAR note dated 9/2/2022 at 8:28 p.m. documented for the Sertraline and Lipitor medications, "On order." The EMAR note for the Flagy, dated 9/3/2022 at 12:07 a.m. documented, "Awaiting delivery." The on-site emergency pharmacy dispensing machine inventory list was reviewed. The following was documented as being in the pharmacy dispensing machine inventory list was reviewed. The following was documented as being in the phar	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A BUILDIN 495401 ROVIDER OR SUPPLIER 495401 B. WING_ ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 29 administered. F 6 The EMAR note dated 9/2/2022 at 8:28 p.m. documented for the Sertraline and Lipitor medications, "On order." The EMAR note for the Flagyl, dated 9/3/2022 at 12:07 a.m. documented, "Awaiting delivery." F 6 The on-site emergency pharmacy dispensing machine inventory list was reviewed. The following was documented as being in the pharmacy machine on site: Atorvastatin 40 mg tablets - PAR level is 10 tablets. Sertraline 50 mg tablets - PAR level is 10 tablets. Sertraline 50 mg tablets - PAR level is 10 tablets. Sertraline 50 mg tablets - PAR level is 10 tablets. So ng tablets - PAR level is 10 tablets. Con 1/18/2023 at 2:51 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the care plan was to let staff know what was needed to care for the resident. LPN #3 stated that the care plan was there to help them take care of the residents and help to avoid any incidents. On 1/18/2023 at 3:47 p.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 stated that the purpose of the care plan was to plan the residents care and to	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIFLE CONSTRUCTION A BUILDING ROVIDER OR SUPPLIER 495401 B. WING RETREAT AT IRON BRIDGE STREET ADDRESS SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEX TAG PREEX (EACH CROSS Continued From page 29 administered. F 656 The EMAR note dated 9/2/2022 at 8:28 p.m. documented for the Sertraline and Lipitor medications, "On order." The EMAR note for the Flagyl, dated 9/3/2022 at 12:07 a.m. documented, "Awaiting delivery." F 656 The on-site emergency pharmacy dispensing machine inventory list was reviewed. The following was documented as being in the pharmacy machine on site: Atorvastatin 40 mg tablets - PAR level is 10 tablets. Sertraline 100 mg tablets - PAR level is 10 tablets. Sertraline 100 mg tablets - PAR level is 10 tablets. Sertraline 100 mg tablets - PAR level is 10 tablets. Sertraline 100 mg tablets - PAR level is 10 tablets. Contured with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan was to let staff know what was needed to care for the resident. LPN #3 stated that the care plan was there to help them take care of the residents and help to avoid any incidents. On 1/18/2023 at 3:47 p.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 stated that the purpose of the care plan was to plan the residents care and to </td <td>S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION A BUILDING </td> <td>MENT OF HEALTH AND HUMAN SERVICES O S FOR MEDICARE & MEDICAD SERVICES O DEFICIENCES (MILTIPLE CONSTRUCTION A BUILDING CORRECTION (MILTIPLE CONSTRUCTION A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (REAT HOFFICINON VISITE PRICEICED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 administered. The EMAR note dated 9/2/2022 at 8:28 p.m. documented for the Sertraline and Lipitor medications, "On order," The EMAR note for the Flagy, diated 9/3/2022 at 12:07 a.m. documented, "Awaiting delivery." 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RN #3 stated that the purpose of the</td>	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION A BUILDING	MENT OF HEALTH AND HUMAN SERVICES O S FOR MEDICARE & MEDICAD SERVICES O DEFICIENCES (MILTIPLE CONSTRUCTION A BUILDING CORRECTION (MILTIPLE CONSTRUCTION A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (REAT HOFFICINON VISITE PRICEICED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 administered. The EMAR note dated 9/2/2022 at 8:28 p.m. documented for the Sertraline and Lipitor medications, "On order," The EMAR note for the Flagy, diated 9/3/2022 at 12:07 a.m. documented, "Awaiting delivery." The on-site emergency pharmacy dispensing machine inventory list was reviewed. 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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/07/2023 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		495401	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	TYLER'S RETREAT AT IRON BRIDGE			1	12001 IRON BRIDGE RD		
TILER 3	ITLER S RETREAT AT IKON BRIDGE			0	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	Continued From page	30	F	656			
	The facility policy, "Co Policy," documented i "The facility must dev Person Centered Car includes measurable meet the resident's m and psychosocial nee comprehensive asses be familiar with each approaches must be i ASM #1, the administ director of nursing, we above on 1/19/2023 a No further information w following website: https://medlineplus.go tml (2) This information w following website: https://medlineplus.go tml (3) This information w following website: https://medlineplus.go tml (4) This information w following website: https://medlineplus.go tml (5) This information w following website: https://medlineplus.go tml (5) This information w following website: https://medlineplus.go tml	omprehensive Care Planning in part, "PROCEDURE: A) elop a comprehensive e Plan for each resident that objectives and timetables to edical, nursing, and mental dos that are identified in the ssmentsD) All staff must resident's Care Plan and all implemented." rator, and ASM #2, the ere made aware of the at 9:49 a.m. n was obtained prior to exit. vas obtained from the ov/druginfo/meds/a600045.h vas obtained from the ov/druginfo/meds/a697009.h vas obtained from the ov/druginfo/meds/a697048.h vas obtained from the ov/druginfo/meds/a697048.h					

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495401	B. WING_				C / 19/2023
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD		
				C	HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	provide pressure ulce B. place a fall mat to the On the most recent M assessment, a quarter (assessment reference resident scored 3 out interview for mental s resident was severely decisions. The assess having one Stage 3 p having any falls since A. The comprehensive documented in part, " integrity r/t (related to peripheral neuropathy integrity: Hx of Chroni (abdominal) fold. 6/3, left heel (resolved 1/1 "Interventions/Tasks" "Treatments per orc 03/19/2015." The wound physician 1/10/2023 for R23 do "Resolved stage 3 F heel contributing far intake, dementia, rest fragile skin. Care for p weeks) to left heel as prep/barrier film to wo daily"	apprehensive care plan to A. For treatment as ordered and the left side of the bed. IDS (minimum data set) erly assessment with an ARD be date) of 12/15/2022, the of 15 on the BIMS (brief tatus), indicating the are impaired for making daily assment documented R23 ressure injury and not the prior assessment. We care plan for R23 Risk for impaired skin) impaired mobility and y. Actual impaired skin ic rash under abd /22 DTI (deep tissue injury) 0/23)" Under it documented in part, der. Date Initiated: progress note dated cumented in part, PI (pressure injury) at left ctors are poor mobility, poor tless legs causing friction, prevention x2/weeks (for two follows: - Apply skin bund bed Provide this care an orders failed to evidence prep to the left heel as	F	556	DEFICIENCY)		
	-	prep to the left heel as pund physician progress					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495401	B. WING				C / 19/2023
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE			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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	32	F	656	5		
		electronic treatment) dated 1/1/2023-1/31/2023 ence a treatment to the left					
	conducted with RN (r manager. RN #3 stat care plan was to plan have a document for prevent incidents. RN the care plans to aler individualized needs. physician progress no	p.m., an interview was egistered nurse) #3, unit ted that the purpose of the the residents care and to staff to reference to help N #3 stated that they used t the staff to the resident's RN #3 reviewed the wound ote dated 1/10/2023, R23's					
	was no order put in fo	eTAR and stated that there or the skin prep. RN #3 have missed the order and					
	was made of R23 in b	1:49 a.m., an observation bed in their room. No fall the left side of R23's bed.					
		ns on 1/17/2023 at 3:52 p.m. 3 a.m. revealed R23 in bed e left side of the bed.					
	further falls related to impairment, and dem 05/11/2016" Under	Hx of actual falls- Risk for weakness, visual/hearing entia. Date Initiated: "Interventions/Tasks" it Fall mat on left side of bed					
	"Fall mat on left side	for R23 documented in part, of resident bed when shift for for safety. Order					

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ICAID SERVICES					
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		_		
495401	B. WING _			C 01/19/2023	
		STREET ADDRESS, CITY,	, STATE, ZIP CODE		
		12001 IRON BRIDGE RE)		
		CHESTER, VA 23831			
IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI) TAG	(EACH COR	RECTIVE ACTION SHOULD BE		
h., an interview was need practical nurse) #3. arpose of the care plan t was needed to care for ted that the care plan ake care of the residents idents. LPN #3 stated dated when there were any new interventions LPN #3 stated that they e care plan if they were own when R23 was in h., ASM (administrative ministrator, ASM #2, the #3, the assistant director egional director of I #5, the regional vice ere made aware of the as provided prior to exit. acility staff failed to nsive care plan for the per the physician's cord revealed a 0/20/22 for "Oxygen via nasal cannula every and at 2:25 PM, ent revealed the oxygen	F	56			
	Agstation NUMBER: 495401 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) A., an interview was used practical nurse) #3. Impose of the care plan the was needed to care for ed that the care plan the care of the residents dents. LPN #3 stated dated when there were any new interventions LPN #3 stated that they e care plan if they were own when R23 was in A., ASM (administrative ninistrator, ASM #2, the #3, the assistant director egional director of #5, the regional vice ere made aware of the s provided prior to exit. acility staff failed to hysice care plan for the per the physician's Cord revealed a D/20/22 for "Oxygen via nasal cannula every	PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN 495401 B. WING_ ENT OF DEFICIENCIES ID ST BE PRECEDED BY FULL PREFIX DENTIFYING INFORMATION) TAG F 6 , an interview was nsed practical nurse) #3. Irpose of the care plan twas needed to care for ed that the care plan ke care of the residents dents. LPN #3 stated dated when there were any new interventions _PN #3 stated that they e care plan if they were own when R23 was in I., ASM (administrative ninistrator, ASM #2, the #3, the assistant director egional director of #5, the regional vice ere made aware of the s provided prior to exit. acility staff failed to nsive care plan for the per the physician's cord revealed a D/20/222 for "Oxygen via nasal cannula every	PROVIDER/SUPPLIER/CLIA (x2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION 495401 B. WING STREET ADDRESS, CITY 12001 IRON BRIDGE RI CHESTER, VA 23831 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL PREFIX CROSS-REFE ID PREFIX ST BE PRECEDED BY FULL DE PRECEDED BY FULL DE PREFIX TAG STREET ADDRESS, CITY ID PREFIX CHESTER, VA 23831 DENTIFYING INFORMATION) F 6556 ID PREFIX TAG REFIX TAG ID PREFIX TAG TAG TAG T	PROVIDERSUPPLERICLA (X2) MULTIPLE CONSTRUCTION A BUILDING	PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) MULTIPLE CONSTRUCTION A BUILDING (X3) MULTIPLE CONSTRUCTION A BUILDING (X3) MULTIPLE CONSTRUCTION A BUILDING (X3) MULTIPLE CONSTRUCTION B WING (X3) WING (X3) WING (X3) WING (X4) WING B WING (X4) WING B WING (X4) WING B WING (X4) WING B WING B WING WING WING B WING WING B WING WING B WING WING WING B WING WING WING B WING WING WING B WING WING WING WING B WING WING WING B WING WING WING B WING WING WING WING B WING WING WING WING B WING WING WING WING WING B WING WING WING WING WING WING WING B WING WING WING WING WING WING WING WING

Facility ID: VA0402

If continuation sheet Page 34 of 78

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		495401	B. WING			0	C 1/19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	set at 1.5 liters as evi flow meter centered of and 2 liter marks. A review of the compu- revealed one dated 8 receiving continuous plan included an inter "Administer oxygen a On 1/19/23 at 10:00 A conducted with LPN # Nurse). She stated th oxygen was set at the that if it was not at 3 I then the care plan was stated that for this res- oxygen be at the right gets hypoxic. A review of the facility Care Planning Policy' conducted. This polic staff must be familiar Plan and all approach On 1/19/23 at approx (the Administrator) ar Nursing) were made a further information was survey 4. For Resident #21, implement the compu- ensure that bilateral fa	denced by the ball of the on the line between the 1 rehensive care plan /27/21 for "Resident is oxygen therapy." This care vention dated 8/27/21 for s ordered." AM an interview was #2 (Licensed Practical nat when she checked, the e correct rate. She stated iters when it was observed, us not being followed. She sident, it is important the t rate because the resident rate because the resident of policy "Comprehensive " that was provided, was by documented, "D) All with each resident's Care ness must be implemented" imately 10:30 AM, ASM #1 nd ASM #2 (the Director of aware of the findings. No as provided by the end of the the facility staff failed to ehensive care plan to all mats were in place.	F	656			

Facility ID: VA0402

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUF COMPLET 495401 B. WING 01/19/. NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	SURVEY ETED
495401 B. WING 01/19/	
	9/2023
TYLER'S RETREAT AT IRON BRIDGE 12001 IRON BRIDGE RD CHESTER, VA 23831	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656 Continued From page 35 for further falls" This care plan included an intervention dated 7/19/21 for "Fall mats on both sides of bed." F 656 A review of the clinical record revealed the January 2023 eTAR (electronic treatment administration record.) This document included an item dated 7/20/21 for "Fall Matts [sic] to each side of the bed for safety while in bed every shift for preventative." This document included to record.) This document identified "Day" "Evening" and "Night" as three opportunities each day for staff to sign off that placement of the fall mats had been verified. Staff had completed this sign off each day through 1/18/23. Observations of Resident #21 on 1/17/23 at 10:57 AM, 1/17/23 at 2:30 PM, 1/18/23 at 11:49 AM, 1/18/23 at 2:3.51 PM, and 1/19/23 at 3:38 AM, all revealed Resident #21 in the bed. Three were no fall mats down and no evidence of fall mats anywhere in the room. On 1/19/23 at 10:00 AM an interview was conducted with LPN #2 (Licensed Practical Nurse). She stated that it was her fault because she had taken them up over the weekend to have them cleaned and never replaced them. When asked if the care plan was being followed, she stated it was not. A review of the facility policy "Comprehensive Care Planning Policy" that was provided, was conducted. with policy documentedD) All staff must be familiar with each resident's Care Plan and all approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of	

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING				C / 19/2023
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		05		1	12001 IRON BRIDGE RD		
I YLER'S I	RETREAT AT IRON BRID	GE		0	CHESTER, VA 23831		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 656	further information was survey. 5. The facility failed to comprehensive care p functioning monitoring Resident #68 was add 12/28/22 with diagnos limited to: end stage of The most recent MDS assessment, a Medic with an ARD (assess 1/3/23, coded Section procedures/treatment dialysis "yes". A review of the compt 12/29/22, revealed, "F dialysis treatments 3 stage renal disease). fistula. INTERVENTI dialysis site, apply pro- Fluid restrictions as o Monitor labs and repor abnormalities. Monito site for bleeding or sig No labs/BP (blood pro- Assess/monitor dress dressing if dressing s dialysis. Assess/Mon- bleeding due to antico with transfer needs w Maintain communicat physician per routine. Report any changes i	aware of the findings. No as provided by the end of the o develop a complete plan for dialysis fistula g for Resident #68. mitted to the facility on sis that included but not renal disease 6 (minimum data set) are five-day assessment, ment reference date) of n O-special as coded the resident as rehensive care plan dated FOCUS: Resident receives times weekly. ESRD (end LUE (left upper extremity) ONS: Bleeding occurs from essure. Call 911, if needed. rdered. Meds as ordered. ort to physician any or shunt/vascular catheter gns /symptoms of infection. essure) in shunt arm. sing to shunt. Replace hould come off while not in itor for signs /symptoms of pagulant therapy. Assist hen going to dialysis. ion with dialysis staff and Dialysis per orders.	F	656			
	Maintain communicat physician per routine.	ion with dialysis staff and Dialysis per orders.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391			
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495401	B. WING			C 01/19/2023				
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
TYLER'S F	RETREAT AT IRON BRID	GE			12001 IRON BRIDGE RD CHESTER, VA 23831					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE			
F 656	6 Continued From page 37		F	656	5					
	An interview was conducted on 1/17/23 at 2:15 PM with Resident #68. When asked whether staff monitor her fistula, Resident #68 stated, "No, they do not monitor it here. They do at the dialysis center."									
	An interview was conducted on 1/18/23 at 2:00 PM with LPN (licensed practical nurse) #2. When asked the purpose of the baseline care plan, LPN #2 stated, it is to initiate the plan of care for the resident based on their needs. When asked what should be included on the baseline care plan for a dialysis resident, LPN #2 stated, it should include monitoring their fistula for bleeding, bruit and thrill. If they are on a fluid restriction, monitoring the intake and to communicate with the dialysis center and physician if any changes occur. When asked if the care plan did not include monitoring the fistula for bruit and thrill, was it a complete care plan, LPN #2 stated it was not.									
	(administrative staff n administrator, ASM # ASM #3, assistant dir the regional director o	2, the director of nursing, ector of nursing, ASM #4, of clinical services and ASM president for operations								
F 657 SS=D	No further information Care Plan Timing and CFR(s): 483.21(b)(2)		F	657	7		2/14/23			
	be-	ensive Care Plans orehensive care plan must ′ days after completion of								

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/07/2023 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		495401	B. WING			01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
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 prace the resident and their discent and their resident and their esident report practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and reviteam after each asse comprehensive and cassessments. This REQUIREMENT by: Based on staff intervand clinical record resident failed to riscipling include: For Resident #10 (R1) 	ssessment. terdisciplinary team, that nited to /sician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the quarterly review - is not met as evidenced iew, facility document review view, it was determined the eview and revise the plan for one of 30 residents Resident #10.	F	657	 Resident #10's care plan has be reviewed and updated to reflect histo suicidal ideations. Any resident has the potential to affected. The MDS or designee will conduct 100% audit of current reside care plans to verify any changes in condition have been updated. The DON or designee will education 	ry of be nt	
		IDS (minimum data set) rrly assessment with an ARD			MDS staff, Social Services, Activities Registered Dietician and Unit Manag on facility protocol to ensure care pla	, ers	

Facility ID: VA0402

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		MEDICAID SERVICES				0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE S COMPL	
			A. BUILDING		c c	
		495401	B. WING			9/2023
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•	
				12001 IRON BRIDGE RD		
ILER 3	RETREAT AT IRON BRID	JGE		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 (EACH CORRECTIVE.) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 657	Continued From page	e 39	F 65	57		
		ce date) of 12/23/2022, the	1.00	have been reviewed and	d revised to reflect	
		15 on the BIMS (brief		resident's current status		
	interview for mental s	status) assessment,		included in new hire orie	entation.	
		nt was severely impaired for				
		ns. Section E documented		4) The MDS or design		
	no behaviors.			resident charts (includin new admits, re-admits, r		
	The progress potes f	or R10 documented in part,		change in condition) we		
		9:30 p.m.) Nursing note. Note		then monthly x 2 months		
		inds CNA (certified nursing		residents care plans have		
	, .	ent in his room crying and		and revised to reflect re		
		attempt to commit suicide.		status. The DON or des	-	
		utting tool resembling a cut two superficial wounds		the audit findings and re committee for further re		
		Patient was visibly upset,		recommendations mont		
		nd yelling "I just want to go! I				
		oing to kill myself!" EMS				
		services) was notified and				
		other injuries. No other				
	-	igns stable. T (temperature) respirations) 22 BP (blood				
	, .	ter assessing resident, EMS				
		officers remained on scene.				
		hat they were waiting to hear				
	_	county] Mental Health Crisis				
		I minutes, police stated they				
	· ·	center and were told that				
	the facility. DON (dire	the criteria for removal from				
		ately notified of situation and				
		1 (one to one) observation to				
	maintain safety. Son	[Name of son] notified.				
		ector of nursing) on site to				
	follow up with crisis of	center for possible				
	evaluation."	1:47 p.m.) Nursing note.				
		ted that there will not be any				
		is center at his [sic] time.				
		on 1:1 observation in order				

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 02/07/2023 ORM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) [DATE SURVEY COMPLETED	
		495401	B. WING			C 01/19/2023		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON BRID	GE			001 IRON BRIDGE RD HESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	Note Text: Resident r (complaints of) voiced supervision due to su noted will continue to - "7/23/2022 10:25 (1 Note Text: Resident's to hospital. Resident was on 1:1 - "7/29/2022 14:36 (2 (physician assistant/r noteReadmitted on due to suicidal attemp States he had roman member and reported was told the staff is m plans on moving to at [Name of psychiatric medications adjusted was sent back to to th Review of the facility 7/22/2022 documenter incident, staff statem services contact, the 7/25/2022 and behav R10 dated 8/11/2022 The comprehensive of evidence a review or self-harm attempt on Review of the clinical any self-harming beh On 1/18/2023 at 2:51	til further notice. Will :59 a.m.) Nursing note. ested well, no c/o d, continue on 1:1 icide attempt no problems monitor." 0:25 a.m.) Nursing note. • son in to transport resident until son arrived." :36 p.m.) Physician/PA/NP nurse practitioner) Progress 7/29/22 after being sent out to twhere he cut his wrist. tic feelings toward a staff fly felt depressed after he harried with children and has nother state. He was sent to hospital] for observation - and behavior improved and he facility" investigation dated ed a summary of the ents, nursing notes, social psychiatric evaluation dated ioral health assessments for , 8/25/2022 and 9/1/2022.	F	657				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 02/07/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING	_	C 01/19/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE		2001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	was to let staff know of the resident. LPN #3 was there to help ther and help to avoid any On 1/18/2023 at 3:47 conducted with RN (re manager. RN #3 stat care plan was to plan have a document for prevent incidents. RN the care plans to alert individualized needs. R10's care plan and s any information regar on 7/22/2022 and that been revised after the On 1/18/2023 at 3:10 conducted with ASM member) #3, the assis ASM #3 stated that th on call on 7/22/2022 a staff had called them. had checked R10's re nothing in the room th themselves with. ASI already on 1:1 when the spoken with the police mental health authorit the resident could not ASM #3 stated that th member was with R10 son had come to take psychiatric hospital the	e purpose of the care plan what was needed to care for stated that the care plan m take care of the residents incidents. p.m., an interview was egistered nurse) #3, unit ed that the purpose of the the residents care and to staff to reference to help N#3 stated that they used the staff to the resident's RN #3 stated reviewed stated that they did not see ding the self-harm attempt t the care plan should have e incident. p.m., an interview was (administrative staff stant director of nursing. rey were the staff member and they had come in when ASM #3 stated that they bom to make sure there was nat they could use to hurt W #3 stated that R10 was they arrived and they had e officers and the local ty but they had advised that is be taken for evaluation. rey had made sure a staff 0 the entire night and the them for evaluation at the e next morning. ASM #3 psychiatry services and	F 657				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CO	NO. 0938-0391 TE SURVEY MPLETED C 1/19/2023
	1/19/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS OF STATE 7/2 CODE	
STREET ADDRESS, GIT, STATE, ZIP GODE	
TYLER'S RETREAT AT IRON BRIDGE 12001 IRON BRIDGE RD CHESTER, VA 23831	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 Continued From page 42 F 657 On 1/18/2023 at 4:09 p.m., an interview was conducted with OSM (other staff member) #3, social services. OSM #3 stated that they followed R10 closely. OSM #3 stated that when the incident happened on 7/22/2022 they focused on keeping the resident safe and getting them the heip they needed and had forgotten to update the care plan when they came back from the hospital. OSM #3 stated that it needed to be done. F The facility policy, "Comprehensive Care Planning Policy" revised 71/9/2019 documented in part, "Residents who have returned from the hospital in the past week. Their previous MDS and Care Plan must be reviewed and updated" F On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations were made aware of the concern. F No further information was obtained prior to exit. SS=D CFR(s): 483.21(b)(3) Comprehensive Care Plans The services provided Meet Professional Standards SS=D CFR(s): 483.21(b)(3)(0) F 658 Services Provided or arranged by the facility, as outlined by the comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to follow 1) Resident #123 no longer resides in the facility. The nurse caring for Resident #123 that failed to notify the physician of	2/14/23

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	S FUR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED	
		495401	B. WING			C 01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON BRID	OGE		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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 658	Continued From page	e 43	F 65	8			
	professional standard administration. to cla	ds of practice for medication rify a physician order for one survey sample, Resident		antibiotic not administered has t educated on following professio standards of practice to notify th physician for clarification of an o	nal ie		
		d to clarify a physician order time of an IV (intravenous)		 Any resident has the potent affected. An audit of medication administration records for the pa will be reviewed for clarity and ti execution of orders. Any variance addressed. 	ast 7 days imely		
	assessment, a Medic with an assessment of the resident scored a interview for mental s resident was severely decisions. In Section resident was coded a and antibiotics during The physician order of documented, "Ceftria Reconstituted 2 GM infections) (1), Use 2 every 24 hours relate days." The August 2022 MA order with a schedule	as receiving antidepressants g the look back period.		 3) The Director of Nursing (DC designee will educate 100% nur their responsibility in clarifying p orders to include the five rights a administration. Education will be in new hire orientation. 4) The DON or designee will a medication administration record weekly x 4 weeks then monthly months to verify medication order clear according to the five rights administration, any variances w addressed. The audit findings a to the QAPI committee for further and recommendations monthly months. 	ses on hysician of drug e included audit ds during x 2 ers are of drug ill be nd report er review		
	documented in part, abscess, PICC line." documented in part,						

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	. ,	E CONSTRUCTION	(X		
			(/~	(X3) DATE SURVEY COMPLETED	
495401	B. WING		_	C 01/19/2023	
NAME OF PROVIDER OR SUPPLIER	S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
TYLER'S RETREAT AT IRON BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 658 Continued From page 44	F 658	3			
An interview was conducted with LPN (licensed practical nurse) #4, on 1/19/2023 at 9:25 a.m. When asked if a new admission arrives with an order for intravenous antibiotics, how does the order get onto the MAR, LPN #4 stated she would have looked on the paperwork from the hospital to see when it was last given and then assign that time on the MAR at the facility. The above MAR was reviewed with LPN #4. When asked if the order needed to be clarified, LPN #4 stated, yes. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/19/2023 at 9:36 a.m. When asked the process for when a new admission comes with physician orders for IV antibiotics, ASM #2 stated if the medication is scheduled and it hasn't come in from the pharmacy, ASM #2 stated they check the (name of pharmacy dispensing machine). If it's not there you call the doctor and follow their instructions. When asked where this is documented, ASM #2 stated it should be in a nurse's note. The time documented on the MAR for the above medication was reviewed with ASM #2, ASM #2 stated there should be a time documented for the administration. When asked what time should be documented, ASM #2 stated, if it's given every 24 hours then our scheduled time is 9:00 a.m. but I would have checked when it was last given at the hospital prior to transfer and follow that time. Per Fundamentals of Nursing, Lippincott, Williams & Wilkins, "Always clarify with the prescriber any medication order that is unclear or seems inappropriate." (2)					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF		
		495401	B. WING			01/19/2023		
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S I	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD HESTER, VA 23831			
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 658	ASM #1, the administ made aware of the at a.m. No further information (1) This information w following website:	rator, and ASM #2, were hove on 1/19/2023 at 9:49 h was obtained prior to exit.	F 6	558				
F 661 SS=D	tml (2) Fundamentals of M & Wilkins, page 553. Discharge Summary	Nursing, Lippincott, Williams	F 6	361			2/14/23	
	must have a discharg but is not limited to, th (i) A recapitulation of includes, but is not lim of illness/treatment or radiology, and consul (ii) A final summary of include items in parage the time of the dischar release to authorized the consent of the rest representative. (iii) Reconciliation of a medications with the re- over-the-counter). (iv) A post-discharge developed with the pa- and, with the resident representative(s), white representative(s), white	cipates discharge, a resident e summary that includes, he following: the resident's stay that hited to, diagnoses, course therapy, and pertinent lab, tation results. The resident's status to graph (b)(1) of §483.20, at rge that is available for persons and agencies, with ident or resident's all pre-discharge resident's post-discharge scribed and						

Facility ID: VA0402

If continuation sheet Page 46 of 78

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/07/202 M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495401	B. WING			01/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD HESTER, VA 23831		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 661	the individual plans to that have been made care and any post-dis non-medical services This REQUIREMENT by: Based on staff interv review, and clinical re- determined that the fa a complete discharge residents in the surve The findings include: For Resident #70 (R7 evidence a discharge recapitulation of the re- summary of the resid discharge, reconciliat medications, and a po- for the discharge on 1 On the most recent M discharge assessmen reference date) of 10, coded as being sever daily decisions. The progress notes fo "10/27/2022 11:31 (1 Resident discharged van with attendant. R belongings with her a	of care must indicate where oreside, any arrangements for the resident's follow up scharge medical and is not met as evidenced iew, facility document ecord review, it was acility staff failed to evidence e summary for one of 30 ey sample, Resident #70. Y0), the facility staff failed to e summary that included a esident's stay, a final ent's status at the time of ion of all pre-discharge resident's post discharge ost discharge plan of care 10/27/2022. IDS (minimum data set), a nt with an ARD (assessment /27/2022, the resident was rely impaired for making or R70 documented in part, 1:31 a.m.) Note Text: home left via transportation esident took all her t discharge."	F	661	 Resident #70 discharge summary been completed. Any resident has the potential to b affected. A 100% audit of discharged residents in the past 30 days will be completed to verify discharge requirements have been completed per facility policy. The Director of Nursing or designed will educate 100% nurses on the facility policy on requirements for discharge. Education will be included in new hire orientation. The Director of Nursing or designed will review all discharges weekly x 4 weeks then monthly x 2 months to verif all requirements have been addressed facility discharge planning policy. The DON or designee will review the audit findings and report to the QAPI commit for further review and recommendations monthly x 3 months. The audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months. 	e r ee fy per ttee is	
	-	Canceled: Resident plans to ity. Date Initiated:			ility ID: VA0402		at Page 47 of

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FOR	M APPROVED D. 0938-0391			
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	495401	B. WING			C 01/19/2023				
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE					
TYLER'S RETREAT AT IRON BRIDG	E		12001 IRON BRIDGE RD CHESTER, VA 23831						
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE			
 Provide resident/family upon discharge. Date 10/24/2022CANCELL resident/family will receinstructions to enable a community. Date Initial Further review of the cevidence a discharge serecapitulation of the resident discharge, reconciliation medications with the remedications and a post the discharge on 10/27 On 1/19/2023 at 8:33 at to ASM (administrative administrator for evided instructions provided to discharge summary that of the resident's stay for 10/27/2022. On 1/19/2023 at 9:47 at director of nursing state any evidence of discharge on 10/27/202 interview was conducted stated that the process nurse to educate the referesentative on the resident's stated that the process nurse to educate the referesentative on the reference of the refere	ons/Tasks: CANCELED: with written instructions Initiated: ED: Upon discharge eive written discharge a safe return to the ated: 10/24/2022" linical record failed to summary that included a sident's stay, a final nt's status at the time of on of all pre-discharge esident's post discharge t discharge plan of care for 7/2022. a.m., a request was made a staff member) #1, the nce of discharge to the resident and the at included a recapitulation or the discharge on a.m., ASM #3, the assistant ed that they did not have arge instructions or a sident's stay for the 22. At that time an ed with ASM #3. ASM #3 is was for the discharge esident and/or the medications and discharge	F	661						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 02/07/2023 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		495401	B. WING		_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	2001 IRON BRIDGE RD			
TYLER'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 PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 661	or concerns about the ASM #3 reviewed R7 that there was no disc completed for them. The facility policy, "Di revised 9/24/2020 do Discharge Summary/I discharge is anticipate discharge summary/I is not limited to, the for a. Summary of Stay. J stay that includes, but course of illness/treat pertinent lab, radiolog b. Final Summary Ava summary of the reside resident's needs, stre preferences (as ident of the discharge that is available for re and agencies, with the resident's representat Reconciliation. Recor medications (both pre over-the-counter). d. Care. A post-discharge developed with the pa and, with the resident representative(s), whi adjust to his or her ne post-discharge plan of the individual plans to	her they had any questions a discharge instructions. O's clinical record and stated charge assessment scharge planning policy" cumented in part, "4. Instructions. When a ed, [Facility] will develop a netructions that includes, but oblowing: A summary of the resident's t is not limited to, diagnoses, ment or therapy, and ly, and consultation results. ailable for Release. A final ent's status to include, the ngths, goals, life history and ified in the MDS) at the time lease to authorized persons e consent of the resident or tive. c. Medication ciliation of all pre-discharge resident's postdischarge resident of the resident 's consent, the resident 's consent, the resident ch will assist the resident to w living environment. The f care will indicate where o reside, any arrangements for the resident's follow up charge medical and . A copy of the	F 661				

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		ND HUMAN SERVICES			PRINTED: 02/07/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495401	B. WING		C 01/19/2023
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD	
TYLER'S I	RETREAT AT IRON BRID	JGE	с	HESTER, VA 23831	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 661	resident representativi if applicable, and a corresident's medical readoministrator, ASM # ASM #3, the assistant made aware of the ada No further information Treatment/Svcs to Pr CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b) Skin Integ §483.25(b)(1) Pressue Based on the compresent resident, the facility m (i) A resident receives professional standard pressure ulcers and ou ulcers unless the indid demonstrates that the (ii) A resident with pro- necessary treatment with professional standard promote healing, pre- new ulcers from deve This REQUIREMENT by: Based on clinical rec and facility document	e resident's consent, the ve(s), the receiving provider, opy will be filed in the cord" B a.m., ASM #1, the t2, the director of nursing and at director of nursing were bove finding n was provided prior to exit. revent/Heal Pressure Ulcer (i)(ii) grity are ulcers. ehensive assessment of a nust ensure that- is care, consistent with does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to vent infection and prevent eloping. T is not met as evidenced cord review, staff interview t review it was determined ailed to obtain a physician	F 661	 Resident #23 recommendation fro wound care provider for application of prep to resolved pressure injury left he has been activated. 	skin
		nealed pressure injury for		 2) Any resident has the potential to baffected. An audit of wound care prov recommendations for past week has based. 	ider

Event ID: I8OZ11

Facility ID: VA0402

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	-	D HUMAN SERVICES MEDICAID SERVICES	-			FORM	D: 02/07/2023 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		495401	B. WING				C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TYLER'S	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD		
			-	C	HESTER, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	• 50	F	686			
	The findings include:				reviewed to verify recommendations		
	For Desident #22 (D2				activated. Any variances will be		
		3), the facility staff failed to provide treatment for a			addressed promptly.		
	healed Stage 3 press	ure injury (1).			3) The DON or designee will educat	е	
	On the most recent M	IDS (minimum data set)			100% nurses on their responsibility in ensuring wound care treatment orders	are	
	assessment, a quarte	rly assessment with an ARD			transcribed and carried out according		
		e date) of 12/15/2022, the of 15 on the BIMS (brief			physicians orders. Education will be included in new hire orientation.		
	interview for mental s				included in new file offentation.		
	-	impaired for making daily			4) The DON or designee will audit		
	one Stage 3 pressure	documented R23 having			wound care provider treatment recommendations weekly x 4 weeks the	en	
					monthly x 2 months to verify wound ca		
		or R23 documented in part, :00 a.m.) Note Text: Wound			treatment recommendations have bee transcribed and carried out. The DON		
		ge: 3 Wound Location L			designee will review the audit findings		
	(left) heelTreatment	Wound care to left heel as			report to the QAPI committee for furthe		
		ep q (every) shift. Area is shift ppx (prophylaxis)."			review and recommendations monthly months.	х З	
	The weekly wound as documented in part,	sessment for R23					
		:00 a.m.)Wound Type:					
	Pressure; Stage: 3; W	/ound Location: L					
	heelArea is resolved	d skin prep q shift ppx."					
	The wound physician						
	1/10/2023 for R23 do	cumented in part, Pl (pressure injury) at left					
		ctors are poor mobility, poor					
		less legs causing friction,					
	fragile skin. Care for p weeks) to left heel as	prevention x2/weeks (for two follows: - Apply skin					
	prep/barrier film to wo	ound bed Provide this care					
	daily"						
	The weekly skin asse	ssment for R23 dated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495401	B. WING			01	/19/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RETREAT AT IRON BRID	CE.		.	12001 IRON BRIDGE RD		
TILLKO		6L			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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	Continued From page 1/17/2023 documente tissue" Review of the physici an order for the skin p documented in the wo note on 1/10/2023. Review of the eTAR (administration record for R23 failed to evide heel after 1/11/2023. R23's use of heel lift f on the left foot and he The comprehensive of documented in part, " integrity r/t (related to peripheral neuropathy integrity: Hx of Chron (abdominal) fold. 6/3 left heel (resolved 1/1 On 1/18/2023 at 3:47 conducted with RN (r manager. RN #3 stated to sent them their progree for treatments in them reviewed them and m based on the notes.	e 51 ed in part, "Left heel scar an orders failed to evidence orep to the left heel as bund physician progress electronic treatment) dated 1/1/2023-1/31/2023 ence a treatment to the left The eTAR documented boots at all times, no shoe eals floated while in bed. eare plan for R23 Risk for impaired skin) impaired mobility and /. Actual impaired skin ic rash under abd /22 DTI (deep tissue injury) 0/23)" p.m., an interview was egistered nurse) #3, unit ed that the wound physician and they rounded with hat the wound physician ess notes with new orders		686	DEFICIENCY)		
	physician rounds as t room to room so they note in front of them t changes. RN #3 state pressure injury had he	hey moved quickly from waited to have the progress o go through and make the ed that R23's left heel					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	PLE CONSTRUCTION		SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							с
		495401	B. WING			01	19/2023
NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
	RETREAT AT IRON BRID	<u>CE</u>			12001 IRON BRIDGE RD		
TILEKSI		GE			CHESTER, VA 23831		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
IAG				,	DEFICIENCY)		
F 686	Continued From page	e 52	F	68	36		
		tment to the area. RN #3					
		physician progress note					
		b's physician orders and					
		there was no order put in					
	for the skin prep. RN	#3 stated that they must					
	have missed the orde	er and did not put it in.					
		in and Wound Care Best					
		0/2022 documented in part,					
	"Purpose: To provid	and wound treatment to					
	prevent unavoidable						
	· ·	sure injuries and wounds will					
		nce-based interventions as					
	ordered by the provid						
	On 1/18/2023 at 4:33	p.m., ASM (administrative					
		administrator, ASM #2, the					
	, , ,	SM #3, the assistant director					
		he regional director of					
	clinical services and A	ASM #5, the regional vice					
	president of operatior	ns were made aware of the					
	concern.						
	No further information	n was provided prior to exit.					
	(1) Pressure Ulcer						
		area of the skin that breaks					
		g keeps rubbing or pressing					
	-	ssure sores are grouped by					
		oms. Stage I is the mildest					
		worst. Stage I: A reddened,					
		tin that does not turn white					
		s a sign that a pressure ulcer nay be warm or cool, firm or					
	•	in blisters or forms an open					
	-	d the sore may be red and					
		ne skin now develops an					
	-	lled a crater. The tissue					

Facility ID: VA0402

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TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		495401	B. WING _		0	C 1/19/2023
	ROVIDER OR SUPPLIER	GE		STREET ADDRESS, CITY, STATE, ZII 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 686	see body fat in the cr pressure ulcer has be damage to the muscl to tendons and joints obtained from the we https://medlineplus.ge 00740.htm.	haged. You may be able to ater. Stage IV: The ecome so deep that there is e and bone, and sometimes . This information was		586		2/14/23
SS=D	as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio record review, and fa was determined that	ure that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent is not met as evidenced n, staff interview, clinical cility document review, it the facility staff failed to		 Resident #21 fall ma in place per care planned 		
	 implement fall interver for two of 30 resident Residents #21 and #2 The findings include: 1. For Resident #21, ensure bilateral fall m plan of care. A review of the comp revealed one dated 3 for further falls" Th 	ntions per the plan of care s in the survey sample; 23. the facility staff failed to hats were in place per the		 Any resident has the affected. A 100% audit w to verify fall mats are in p plan, any variances will b The Director of Nurs will educate 100% nursir ensuring fall mats are in plan. Education will be in hire orientation. The Director of Nurs will random rounds week monthly 2 months to verify and a statement of the statement	vill be completed blace per care be addressed. and or designee ng staff on place per care icluded in new sing or designee dy x 4 weeks then	

Event ID: I8OZ11

Facility ID: VA0402

If continuation sheet Page 54 of 78

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/07/2023 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		495401	B. WING			_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•••	
TYLER'S	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD HESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
F 689	sides of bed." A review of the clinical January 2023 eTAR (administration record) dated 7/20/21 for "Fai the bed for safety whi preventative." This de "Evening" and "Night" day for staff to sign of mats had been verifie sign off each day thro survey review). Observations of Resid AM, 1/17/23 at 2:30 F 1/18/23 at 3:51 PM, a revealed Resident #2 were no fall mats nex of fall mats anywhere On 1/19/23 at 10:00 A conducted with LPN # Nurse). She stated th been down. She state because she had take weekend to have ther replaced them. A review of the facility Management Policy" conducted. This polic will be assessed for fa quarterly, after any fa are identified, prevent place and care plance and investigatedInd	al record revealed the electronic treatment) which included an item II Matts [sic] to each side of le in bed every shift for ocument identified "Day" ' as three opportunities each if that placement of the fall ed. Staff had completed this ough 1/18/23 (the date of the fall had completed this ough 1/18/23 at 11:49 AM, ind 1/19/23 at 8:38 AM, 1 in the bed however there t to the bed and no evidence in the room. AM an interview was #2 (Licensed Practical hat the fall mats should have ed that it was her fault en them up over the m cleaned and never of policy "Fall Prevention and that was provided, was cy documented, "Residents all risk[s] on admission, II, and as needed. If risks tive measures will be put in ed. All falls will be reviewed ividualized interventions will ed on this assessment and	F	689	place per care plan. Audit findings reported to the QAF review and recomm months.		her	

If continuation sheet Page 55 of 78

-					FORM	APPROVED			
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED			
	495401	B. WING				C 19/2023			
ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE					
RETREAT AT IRON BRID	GE								
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
Continued From page	: 55	F	689						
(the Administrator) an Nursing) were made a further information was survey. 2. For Resident #23 (to implement fall mats On the most recent M assessment, a quarte (assessment reference resident scored 3 out interview for mental s resident was severely decisions. The asses having any falls since On 1/17/2023 at 11:44 made of R23 in bed ir mat was observed to Additional observation and 1/18/2023 at 8:48 with no fall mat on the The physician orders "Fall mat on left side of resident in bed every Date: 03/27/2022." The comprehensive of documented in part, " further falls related to impairment, and dem 05/11/2016" Under	d ASM #2 (the Director of aware of the findings. No as provided by the end of the R23), the facility staff failed as ordered. DS (minimum data set) rly assessment with an ARD the date) of 12/15/2022, the of 15 on the BIMS (brief tatus), indicating the mipaired for making daily asment documented R23 not the prior assessment. D a.m., an observation was their room however no fall the left side of R23's bed. As on 1/17/2023 at 3:52 p.m. a.m. revealed R23 in bed the left side of the bed. for R23 documented in part, of resident bed when shift for for safety. Order are plan for R23 Hx of actual falls- Risk for weakness, visual/hearing entia. Date Initiated: "Interventions/Tasks" it Fall mat on left side of bed								
	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RETREAT AT IRON BRID SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From page On 1/19/23 at approxi (the Administrator) an Nursing) were made a further information wa survey. 2. For Resident #23 (I to implement fall mats On the most recent M assessment, a quarte (assessment reference resident scored 3 out interview for mental s resident was severely decisions. The assess having any falls since On 1/17/2023 at 11:44 made of R23 in bed ir mat was observed to Additional observatior and 1/18/2023 at 8:48 with no fall mat on the The physician orders "Fall mat on left side of resident in bed every Date: 03/27/2022." The comprehensive co documented in part, " further falls related to impairment, and demo 05/11/2016" Under documented in part, "	FORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: <td< td=""><td>RESPOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD ROVIDER OR SUPPLIER 495401 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 55 F On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. F 2. For Resident #23 (R23), the facility staff failed to implement fall mats as ordered. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/15/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The assessment documented R23 not having any falls since the prior assessment. On 1/17/2023 at 11:49 a.m., an observation was made of R23 in bed in their room however no fall mat was observed to the left side of R23's bed. Additional observations on 1/17/2023 at 3:52 p.m. and 1/18/2023 at 8:48 a.m. revealed R23 in bed with no fall mat on the left side of the bed. The physician orders for R23 documented in part, "Fall mat on left side of resident bed when resident in bed every shift for for safety. Order Date: 03/27/20</td><td>ES FOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING A95401 B. WING ROVIDER OR SUPPLIER 495401 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PID PREFIX TAG Continued From page 55 F 685 On 1/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #23 (R23), the facility staff failed to implement fall mats as ordered. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/15/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. The assessment documented R23 not having any falls since the prior assessment. 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WING (2) MULTIPLE CONSTRUCTION A BUILDING MOVIDER OR SUPPLER RETREAT AT IRON BRIDGE RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION REGOVER OFFICIENCY MUST BE PRECIDED BY FULL REQUIDENTIFICATION WINF BE PRECIDED BY FULL REGUIDENTIFICATION WINF BE ADDRECT TO THE APPROPRIATE DEFICIENCY Continued From page 55 C ON 11/19/23 at approximately 10:30 AM, ASM #1 (the Administrator) and ASM #2 (the Director of NUrsing) were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #23 (R23), the facility staff failed to implement fall mats as ordered. On the most recent MDS (minimum data set) assessment, reference data 0 of 12/15/2022, the resident was severely impaired for making daily decisions. 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Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION		(X3) DATE COMP	
		495401	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	IY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI> TAG	(EACH CC	DER'S PLAN OF CORRECTION DRECTIVE ACTION SHOULD E FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	On 1/18/2023 at 2:51 conducted with LPN (LPN #3 stated that sta residents needs for fa and their care plans. kept a list of residents nurses station and the the rooms at times to in place as ordered. If were assessed for fal updated when there w stated that they imple fall mats for residents had a history of falls. the observations on 1 8:48 a.m. and stated	e 56 p.m., an interview was licensed practical nurse) #3. aff were made aware of all mats by physician orders LPN #3 stated that they who utilized fall mats at the e supervisor would check ensure that the mats were LPN #3 stated that residents I risk and the care plan was were any falls. LPN #3 mented interventions like who were at risk for falls or LPN #3 was made aware of /17/2023 and 1/18/2023 at that the mat should have mes when the resident was	F6	89			
F 695 SS=D	staff member) #1, the director of nursing, AS of nursing, ASM #4, th clinical services and A president of operation concern. No further information Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care an The facility must ensu- needs respiratory care care and tracheal suc- care, consistent with	p.m., ASM (administrative administrator, ASM #2, the SM #3, the assistant director he regional director of ASM #5, the regional vice hs were made aware of the h was provided prior to exit. tomy Care and Suctioning ry care, including di tracheal suctioning. ure that a resident who e, including tracheostomy stioning, is provided such professional standards of hensive person-centered	Fé	95			2/14/23

Facility ID: VA0402

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 02/07/2023 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COMF	E SURVEY PLETED
		495401	B. WING				C / 19/2023
	ROVIDER OR SUPPLIER	GE	I	12	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD HESTER, VA 23831	<u> </u>	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	care plan, the resider and 483.65 of this su This REQUIREMENT by: Based on observatio record review, and fa was determined that administer oxygen pe of 30 residents in the #1. The findings include: For Resident #1, the administer oxygen at the physician's order. A review of the clinica physician's order date 3LPM (liters per minu shift" On 1/17/23 at 12:00 F observations of the re rate on the oxygen co set at 1.5 liters as evi flow meter centered of and 2 liter marks. A review of the comp revealed one dated 8 receiving continuous plan included an inter "Administer oxygen at On 1/19/23 at 10:00 A conducted with LPN (#2 . She stated that	 al record revealed a ed 10/20/22 for "Oxygen the) via nasal cannula every PM and at 2:25 PM, esident revealed the oxygen oncentrator flow meter was denced by the ball of the on the line between the 1 rehensive care plan /27/21 for "Resident is oxygen therapy." This care rvention dated 8/27/21 for is ordered." 	F	695	 Resident #1 s oxygen flowrate w adjusted to reflect physicians order up discovery. Any resident has the potential to affected. A 100% audit will be complet to verify oxygen is at prescribed flowr Any variances will be addressed. The Director of Nursing (DON) of designee will educate 100% nurses of their responsibility of following medica provider orders for prescribed oxygen flowrate. Education will be included in hire orientation. The DON or designee will round residents weekly x 4 weeks then mon x 2 months to verify oxygen flowrate i prescribed rate. Audit findings will be reported to the QAPI committee for fur review and recommendations monthly months. 	be ted ate. n al new on 3 thly s at	

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRON FORM APPRON SMB NO. 0938-03	/ED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	<u></u>
		495401	B. WING		C 01/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ON
F 695	that if it was not at 3 li then the physician's o followed. She stated important the oxygen the resident gets hypo A review of the facility Administration" that w conducted. This polic clinicians with demon- administer oxygen via ordered by a provider On 1/19/23 at approxi (the Administrator) an Nursing) were made a	iters when it was observed, orders were not being that for this resident, it is be at the right rate because oxic. Topolicy "Oxygen vas provided, was cy documented, "Licensed strated competence will a the specified route as	F 69	25		
F 698 SS=D	CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensured require dialysis receive with professional standom comprehensive person the residents' goals and This REQUIREMENT by: Based on staff intervit clinical record reviewe review, it was determing provide dialysis care and	re such services, consistent idards of practice, the in-centered care plan, and ind preferences. is not met as evidenced iew, resident interview,	F 69	 Resident #68 has been discharged home. Visit summaries from dialysis we obtained and scanned into electronic medical record. (EMR) Any resident has the potential to be affected. A 100% audit of current residents receiving dialysis services will 	re	

Event ID: I80Z11

Facility ID: VA0402

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTH	PLE CONSTRUCTION	(X3) DATE SUF	RVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLET	
					С	
		495401	B. WING		01/19/	2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
TYLER'S	RETREAT AT IRON BRID	GE		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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE C THE APPROPRIATE	(X5) OMPLETION DATE
F 698	Continued From page	e 59	F 69	98		
	The facility failed to p dialysis facility for 1 o (12/30/22) and 3 of 7 (1/2/23, 1/4/23 and 1/ monitoring of the brui (vibration) in the left u Resident #68 was ad 12/28/22 with diagnos not limited to: end sta mellitus, heart failure fibrillation. The most recent MDS assessment, a Medic with an ARD (assess 1/3/23, coded the res 15 on the BIMS (brief score, indicating the r impaired. Section O-s	rovide communication to the f 1 visits in December 2022 visits in January 2023 (6/23); and failed to evidence t (swishing sound) and thrill upper arm fistula. mitted to the facility on sis that included but were age renal disease, diabetes and paroxysmal atrial S (minimum data set) are five-day assessment, ment reference date) of ident as scoring a 15 out of f interview for mental status) resident was not cognitively		 be audited to verify visit suinformation has been obtain dialysis provider and scan EMR, any variances will b 3) The Director of Nursin designee will educate 100 their responsibility to communication is the EMR. Education will b new hire orientation. 4) The Director of Nursin designee will audit all residiallysis services weekly x monthly x 2 months to ver communication to dialysis pre/post dialysis treatment designee will review the a report to the QAPI commit review and recommendation. 	ined from ned into the e addressed. ng (DON) or % nurses on municate with treatments and s scanned into e included in ng (DON) or dents receiving 4 weeks then ify provider t. The DON or udit findings and tee for further	
	12/29/22, which reveat receives dialysis treat ESRD (end stage reme extremity) fistula. IN occurs from dialysis s 911, if needed. Fluid Meds as ordered. Mo physician any abnorm shunt/vascular cathet /symptoms of infectio pressure) in shunt arr to shunt. Replace dre come off while not in signs /symptoms of b	rehensive care plan dated aled, "FOCUS: Resident tments 3 times weekly. al disease). LUE (left upper TERVENTIONS: Bleeding site, apply pressure. Call restrictions as ordered. onitor labs and report to halities. Monitor ter site for bleeding or signs n. No labs/BP (blood m. Assess/monitor dressing essing if dressing should dialysis. Assess/Monitor for leeding due to anticoagulant transfer needs when going to		months.		

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			(X3) DATE COM	E SURVEY PLETED
		495401	B. WING			01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
TYLER'S RETREAT AT IRON BRIDGE					12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	dialysis. Maintain cor staff and physician per orders. Report any con nursing/physician. A review of physician revealed the following week, Monday/Wedm A review of Resident communication book communication book communication book communication to the visits from 12/30/22-1 were 12/30/22, 1/2/23 A review of Resident administration record- record) for December revealed no evidence bruit/thrill/bleeding at An interview was con PM with Resident #68 her dialysis communi- dialysis center, Resid take the book with me whether staff monitor stated, no, they do no the dialysis center. An interview was con PM with LPN (license asked the purpose of forms, LPN #2 stated pertinent information they vital signs and m- in labs or medications center. When asked	mmunication with dialysis er routine. Dialysis per hanges in condition to the orders, dated 12/29/22, g, "Dialysis three times a esday/Friday at 11 AM." #68's dialysis revealed missing e dialysis facility for 4 of 8 /16/23. The missing dates 3, 1/4/23 and 1/6/23. #68's MAR-TAR (medication -treatment administration 2022 and January 2023 e of monitoring of	F	698	8		

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE	E SURVEY
ANDIEANO	CONTRECTION	IDENTIFICATION NOWBER.	A. BUILD	ING			C
		495401	B. WING				/19/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	for bleeding and if the it for bruit and thrill. V would be documented documented on the M A review of the dialysis approximately 10:00 // "Review of dialysis co that all appropriate ma and other information residents at the time of This information, shall where appropriate the 1. Designated resider birth and social secur 2. Name/address/pho 3. Appropriate medica of resident's illness, in findings. 4. Treatment present designated resident, i any changes in a pati medication, diet or flu On 1/18/23 at approx (administrative staff m administrator, ASM # ASM #3, assistant dir the regional director of #5, the regional vice p were made aware of the On 1/19/23 at 8:00 All dialysis facility was pr dialysis communication	ey have a fistula, we monitor When asked where this d, LPN #2 stated it is IAR-TAR. is contract on 1/18/23 at AM, revealed the following, ontract: Facility shall ensure edical, social, administrative accompany all designated of transfer to the center. I include but is not limited to, e following: nt's name, address, date of ity number. one number of next of kin. al records including history ncluding labs and x-ray y being provided to the ncluding medications and ent's condition, change of id intake." imately 4:30 PM, ASM hember) #1, the 2, the director of nursing, ector of nursing, ASM #4, of clinical services and ASM oresident for operations the findings. M, communication from the rovided, no additional on forms were found. r's "Hemodialysis Care vealed the following,	F	698	8		

Facility ID: VA0402

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
495401		495401	B. WING			C 01/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	signs, pre-treatment of dialysis), medications treatment, time of las additional alerts or in and send with resider	Assessment includes vital weight (unless performed at administered before t meal, fluid intake, any formation and print the tool nt to dialysis (if off-site)."	F	698			
F 727 SS=D	RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1) §483.35(b) Registere §483.35(b)(1) Except paragraph (e) or (f) o must use the services least 8 consecutive h §483.35(b)(2) Except paragraph (e) or (f) o must designate a reg director of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa This REQUIREMENT	-(3) d nurse when waived under f this section, the facility s of a registered nurse for at ours a day, 7 days a week. when waived under f this section, the facility istered nurse to serve as the	F	727			2/14/23
	review, it was determ failed to ensure eight (registered nurse) cor reviewed. The findings include: The facility staff failed	iew and facility document ined that the facility staff consecutive hours of RN verage on three of 34 days d to ensure eight consecutive e for three days, 8/13/2022,			 The DON or designee will educate scheduler on requirements for minimun 8-hour RN coverage. No residents were identified as being affected by the deficient practice. Any resident has the potential to be affected. A review of schedule for next days will be completed to verify a minimum of 8 hours daily RN coverage 	n e e 30	

Facility ID: VA0402

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						0.0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	· · ·	E SURVEY PLETED	
		495401	B WING			С	
	ROVIDER OR SUPPLIER	435401		STREET ADDRESS, CITY, STATE, ZIP CODE	01	/19/2023	
NAME OF F	ROVIDER OR SOFFLIER			12001 IRON BRIDGE RD			
TYLER'S	RETREAT AT IRON BRID	DGE		CHESTER, VA 23831			
(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 727	Continued From pag	e 63	F 727	,			
	Review of the PBJ Si 7/1/2022-9/30/2022 r the facility's requirem Nurse on duty for at I day. The report doct 7/31/2022, 8/13/2022 9/18/2022. On 1/17/2023 at app entrance conference member) #1, the adm facility did not have a in the facility. On 1/17/2023 at app request was made to coverage for the date On 1/17/2023 at 12:5 time card reports for stated that they did not that clocked in on the continue to look. Re documented no RN of 9/4/2022, 9/18/2022. documented bonus p On 1/18/2023 at 11:3 conducted with OSM staffing coordinator. normally had an RN p.m. shift each day d weekends had an RN the 11:00 p.m7:00 a that they also had the	taffing Data Report for revealed concerns related to hent to have a Registered least 8 consecutive hours a umented no RN hours on 2, 8/14/2022, 9/4/2022 and roximately 11:14 a.m., during , ASM (administrative staff ninistrator stated that the any staffing waivers in place roximately 12:00 p.m., a 0 ASM #1 for evidence of RN es listed above. 52 p.m., ASM #1 provided the dates listed above and not have evidence of an RN		 The Director of Nursing or will educate scheduler, RN's, UManagers and supervisors on requirements for minimum 8-ho coverage daily. Education will b in new hire orientation. The Director of Nursing or will review schedule daily during Morning Meeting to verify schedincludes minimum 8-hour RN correquirements are met. Audit find reported to QAPI committee for review and recommendations months. 	nit ur RN e included designee g Clinical dule overage dings to be further		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/07/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495401	B. WING		_		C 19/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE		2001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 727	staff. OSM #2 stated dates above and see On 1/18/2023 at 1:23 they had reviewed the for the dates listed ab timecard evidencing a 7/31/2022. OSM #2 s evidence of an RN for 9/4/2022 or 9/18/2022 The facility policy, "Pa Reporting" undated, of salary RN employee Weekend Salary RN 4). You can then mov to reflect the day they you cannot pay a sala weekThere needs the following job codes 7 ADONRN, MDSRN, F SUPERRN. There is a PBJ Hours 5-7 (RN O you if you have an RN an RN in payroll for th with the DON to see i adjusted and/or you h case that would be tra log" On 1/18/2023 at 4:33 staff member) #1, the director of nursing, ASM #4, th clinical services and A	that they would review the if there was an RN on duty. p.m., OSM #2 stated that e timecards and schedules ove and provided a an RN working 8 hours on stated that they did not have r 8 hours on 8/13/2022, 2. ayroll Based Journal documented in part, "If a works the floor as a nurse, has completed the Transfer form (Attachment e the hours on the time card r worked. Please remember, ary person over 40 hours per to be 8 hours of one of the days week, DON, RN, VRN, RESTRN, and a report in Time Trak called only). This report will show N missing. If you do not have nat day, ensure you meet	F 727				

Facility ID: VA0402

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		ONSTRUCTION		NO. 0938-039 DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
495401		B. WING			C 01/19/2023		
NAME OF PROVIDER OR SUPPLIER		1	STR	EET ADDRESS, CITY, STATE, ZIP COD	E		
TYLER'S RETREAT AT IRON BRIDGE)1 IRON BRIDGE RD ESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 727	Continued From page	e 65	F	727			
F 700		n was presented prior to exit.	_	700			0/4.4/00
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1)	•	F	732			2/14/23
	§483.35(g) Nurse Sta						
	must post the following	equirements. The facility ng information on a daily					
	basis: (i) Facility name.						
	(ii) The current date.						
		and the actual hours worked gories of licensed and					
	unlicensed nursing st	taff directly responsible for					
	resident care per shif (A) Registered nurse						
	(B) Licensed practica	al nurses or licensed					
	vocational nurses (as (C) Certified nurse ai (iv) Resident census.						
	§483.35(g)(2) Posting						
		ost the nurse staffing data h (g)(1) of this section on a					
	daily basis at the beg	inning of each shift.					
	(ii) Data must be pos(A) Clear and readab						
		ace readily accessible to					
		access to posted nurse					
	staffing data. The factor written request, make	cility must, upon oral or e nurse staffing data					
	• •	c for review at a cost not to					
	§483.35(g)(4) Facility requirements. The facility	/ data retention acility must maintain the					
	posted daily nurse st	aomy muor munitain the	1				1

Facility ID: VA0402

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495401	B. WING			/ 19/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TYLER'S	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 732	18 months, or as requise greater. This REQUIREMENT by: Based on observation document review, it we facility staff failed to prinformation prior to the three days observed. The findings include: The facility staff failed information on 1/18/20 the nursing staff work On 1/18/2023 at 8:03 observations of the prinformation in the entry staffing information day On 1/18/2023 at 11:30 conducted with OSM staffing coordinator. nursing schedules we p.m11:00 p.m. and 12 #2 stated that they wo Friday beginning at 83 when they came in eac census in the facility, the day and filled out placed it in the hallward did not post it prior to shift and was not award #2 stated that when the manager on duty was information.	 uired by State law, whichever is not met as evidenced n, staff interview and facility vas determined that the ost daily nurse staffing e start of the shift for one of l to post nurse staffing 023 prior to the beginning of shift. a.m., and 8:29 a.m., osted nurse staffing rance hallway revealed 	F 73	 The scheduler has been educe requirements for posting staffing information at the beginning of the shift of day. Any resident has the potentia affected. The Director of Nursing designee has rounded and verified posting was displayed at the begin day shift. The Director of Nursing or dee will educate scheduler, Unit Mana and supervisors on requirements of posting staffing by start of day shift Education will be included in new orientation. The Director of Nursing or dee will round weekly x 4 weeks then r x 2 months to ensure staff posting been posted prior to start of day sl The DON or designee will review tf findings and report to the QAPI co for further review and recommend monthly x 3 months. 	e first I to be of d staff nning of signee gers of ft daily. hire signee monthly has hift. the audit mmittee	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUP AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495401 B. WING 01/19/	ETED
495401 B. WING 01/19/	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TYLER'S RETREAT AT IRON BRIDGE 12001 IRON BRIDGE RD CHESTER, VA 23831	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONSERTING SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CONSERTION	(X5) COMPLETION DATE
F 732 Continued From page 67 F 732 Policy" with a revision date of 8/13/2020 documented in part, "The facility will post the following information on a daily basis, at the beginning of each shift: Facility name; The current date; Resident census; The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (a) Registered nurses (as defined under State law) (c) Certified nurse aides" F 760 On 1/18/2023 at 4:33 p.m., ASM (administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #1, the administrative of clinical services and ASM #5, the regional vice president of operations were made aware of the concern. F 760 No further information was presented prior to exit. F 760 SS=0 CFR(s): 483.45(f)(2) The facility must ensure that its-gasta.53(5)(C) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: F 760 Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to ensure one of 30 residents in the survey sample was free of a significant medication is not eavailable. 1) Resident # 123 no longer resides in the responsibility to follow medical provider⊡s or davailable. The findings include: 2) Any resident has the potential to be	2/14/23

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STATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	<u>O. 0938-0391</u> E SURVEY PLETED
		495401	B. WING		01	C / 19/2023
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		15/2025
-				12001 IRON BRIDGE RD		
TYLER'S	RETREAT AT IRON BRID	GE		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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	e 68	F 760			
	For R123, the facility intravenous (IV) antib On the most recent M assessment, a Medic with an assessment r the resident scored a interview for mental s resident was severely decisions. In Section resident was coded a and antibiotics during The physician order of documented, "Ceftria Reconstituted 2 GM (infections) (1), Use 20 every 24 hours relate days." The August 2022 MA order with a schedule no scheduled time for medication. On 8/17/7 a "19" on the block w documented as admi "Other/See Nurses N The EMAR (electroni record) note dated 8/ documented, "Just ad The MAR from the hor resident was admitted	staff failed to administer an piotic on 8/17/2022. MDS (minimum data set) pare five-day assessment, reference date of 9/8/2022, "7" on the BIMS (brief status) score, indicating the y impaired for making daily n N - Medications the as receiving antidepressants y the look back period. dated, 8/17/2022, xone Sodium Solution (grams) (used to treat 000 milligrams intravenously ed to abscess of liver for 23 R documented the above ed time of "24h." There was r the administration of the 2022, the nurse documented here it would be nistered. A "19" indicated, otes." c medication administration 17/2022 at 7:36 p.m. dmitted." bspital from which the d from, documented the t dose documented was on n. There was no medication being		affected. An audit of medication administration for past 7 days w completed to verify medications been administered per medical order. Any variances will be ad promptly. 3) The Regional Director of Nursin Assistant Director Nursing on th protocol for auditing medication administration during Clinical M Meeting. The Director of Nursin or designee will educate 100% their responsibility in ensuring r are administered per medical p orders and protocol for obtainin medications from on-site storage notification to medical provider medication not available. Education 4) The Director of Nursing or will audit medication administrat Clinical Morning meeting weekt weeks then monthly x 2 months medications have been administ medications have been administ medical provider s orders, any will be addressed. The DON or will review the audit findings an the QAPI committee for further recommendations monthly x 3 for	vill be s have provider ddressed lursing has ag and he facility n forning ng (DON) nurses on medications rovider⊟s ag ge and if ation will be t. designee tion during ly x 4 s to verify stered per v variances designee d report to review and	

Facility ID: VA0402

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/19/2023	
		495401	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	Continued From page	e 69	F	760			
	documented in part, " abscess, PICC line." documented in part, "						
	machine inventory list following was docume	ented as being in the n site: Ceftriaxone 1 GM vial					
	practical nurse) #4, o When asked about th admission comes and receive their medicati at the computer, verif have the medication y pharmacy dispensing the medications are n doctor and follow their the responsible party above actions are do should be in a nurse's program). The above with LPN #4. LPN #4	ducted with LPN (licensed n 1/19/2023 at 9:25 a.m. e process when a new d it's time for the resident to ons, LPN #4 stated you look y the medication, if you don't you go to the (name of machine). LPN #4 stated if not in there, you call the r instructions and then notify . When asked where the cumented, LPN #4 stated it s note in (name of computer medication was reviewed e stated she believed the name of computer program).					
	nursing, on 1/19/2023 the process for a new physician orders for l' if the medication is so in from the pharmacy	ducted with ASM nember) #2, the director of 3 at 9:36 a.m. When asked 7 admission comes with V antibiotics, ASM #2 stated cheduled and it hasn't come , ASM #2 stated they check cy dispensing machine). If					

Facility ID: VA0402

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	-	D HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		TE SURVEY MPLETED
		495401	B. WING			C C	C 1/19/2023
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S I	RETREAT AT IRON BRID	GE			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	it's not there you call ti instructions. When as documented, ASM #2 nurse's note. The time for the above medicat #2, ASM #2 stated the documented for the a what time should be o if it's give every 24 ho is 9:00 a.m. but I wou was last given at the I follow that time. When considered a significa stated yes, if the resid antibiotics, then it's si The facility policy, "Ge Medication Administra documentation related intravenous medication available. Lippincott Handbook of included: "One of the administering medicat the medications are at the times orderedvo and check the drugs ti if medications are not physician must be not ASM #1, the administ a.m.	the doctor and follow their ked where this is stated it should be in a e documented on the MAR tion was reviewed with ASM ere should be a time dministration. When asked documented, ASM #2 stated, ours then our scheduled time ld have checked when it hospital prior to transfer and n asked if the IV antibiotic is ant medication, ASM #2 dent is requiring IV gnificant for that resident. eneral Dose Preparation and ation," failed to evidence d to the administration of ons and/or medications not of Nursing Procedures responsibilities of the nurse tions is to check to ensure vailable for administration at erify the physician's order to be sure they are correct given for any reason the tified" (2). rator, and ASM #2, were poove on 1/19/2023 at 9:49	F	760			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/07/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495401	B. WING		C 01/19/2023
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CC	•
TYLER'S I	RETREAT AT IRON BRID	GE		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 760	following website: https://medlineplus.go tml	vas obtained from the ov/druginfo/meds/a685032.h	F 7	60	
F 842 SS=D	Bethlehem Pa 2008 p	dentifiable Information	F 84	42	2/14/23
	 (i) A facility may not resident-identifiable to (ii) The facility may represent the facility may represent the facility may represent the factor of the factor	lease information that is			
		rdance with accepted Is and practices, the facility al records on each resident ented; e; and			
	all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, par				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/07/2023 MAPPROVED). 0938-0391	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING				C	
		495401	B. WING				_ 19/2023	
NAME OF PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE				
TYLER'S RETREAT AT IRON BRIDGE					2001 IRON BRIDGE RD			
				С	HESTER, VA 23831			
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	neglect, or domestic v activities, judicial and law enforcement purp purposes, research pur medical examiners, fu a serious threat to hea by and in compliance §483.70(i)(3) The faci record information ag- unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The mea (i) Sufficient informatio (ii) A record of the res (iii) The comprehensiv provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on observation	; activities, reporting of abuse, violence, health oversight administrative proceedings, ooses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services preadmission screening valuations and cted by the State; 's, and other licensed as notes; and ogy and other diagnostic quired under §483.50. 'is not met as evidenced n, staff interview, and clinical	F	342	 Resident #21 fall mats have been 			
	record review, it was	determined that the facility a complete and accurate			placed at bedside bilaterally. Nurse wa educated on verifying orders were carri			

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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		0.	C I/19/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
TYLER'S I	RETREAT AT IRON BRID	GE		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 842	Continued From page	e 73	F 842	2			
	clinical record for one survey sample; Resid	e of 30 residents in the dent #21.		out and documented after implementation.			
		e facility staff failed to ensure ion regarding the placement		 Any resident has the potential affected. A 100% audit of residents orders for fall mats will be reviewed verify fall mats in place with accura documentation. Any variances will be addressed. 	s with I to te		
	AM, 1/17/23 at 2:30 F 1/18/23 at 3:51 PM, a revealed Resident #2	dent #21 on 1/17/23 at 10:57 PM, 1/18/23 at 11:49 AM, and 1/19/23 at 8:38 AM, all 21 in the bed. There were no o evidence of fall mats n.		3) The Director of Nursing (DON) designee will educate nurses on nur responsibility to verify orders carrie and document after implementation Education will be included in new h orientation.	rse's d out ı.		
	January 2023 eTAR (administration record an item dated 7/20/2 side of the bed for sa for preventative." Th "Evening" and "Night day for staff to sign o	.) This document included 1 for "Fall Matts [sic] to each fety while in bed every shift is document identified "Day" " as three opportunities each ff that placement of the fall ed. Staff had completed this		4) The DON or designee will cond random rounds weekly x 4 weeks the monthly 2 months to verify fall mates place and documented accurately p care plan. Audit findings will be rev and reported to the QAPI committee further review and recommendation monthly x 3 months.	nen s in ber viewed e for		
	Nurse). She stated the been down. When as mats were in place we any mats in the room fault because she has	AM an interview was #2 (Licensed Practical hat the fall mats should have sked about documenting that hen in fact there were not , she stated that it was her d taken them up over the m cleaned and never					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED		
		495401	B. WING		0,	C 1/19/2023	
NAME OF PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CO	DE		
TYLER'S I	RETREAT AT IRON BRID	IGE	12001 IRON BRIDGE RD				
			СНЕ	ESTER, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From page	e 74	F 842				
		is care plan included an	1 042				
		19/21 for "Fall mats on both					
		imately 10:30 AM, ASM #1					
		nd ASM #2 (the Director of					
		aware of the findings. No as provided by the end of the					
	survey.						
F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)		F 880			2/14/23	
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable					
	§483.80(a) Infection	prevention and control					
	program.	blich on infaction provention					
		blish an infection prevention (IPCP) that must include, at ving elements:					
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	ipon the facility assessment to §483.70(e) and following					
		n standards, policies, and ogram, which must include,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495401	B. WING			01/19/2023		
NAME OF PROVIDER OR SUPPLIER			<u> </u>	:	STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	TYLER'S RETREAT AT IRON BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 880	 (i) A system of surveil possible communicability infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and trant to be followed to preview; (iv) When and how isour resident; including but (A) The type and durat depending upon the init involved, and (B) A requirement that least restrictive possilic circumstances. (v) The circumstances (v) The circumstances (vi) The hand hygiene by staff involved in direct will transmit the sidentified under the factorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual reverties 	lance designed to identify of can spread to other in possible incidents of se or infections should be assmission-based precautions ent spread of infections; olation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable kin lesions from direct a or their food, if direct the disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of	F	880				

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	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TI	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	l` í	A. BUILDING			
						С	
		495401	B. WING			01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
TYLER'S	RETREAT AT IRON BRID	GE		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 76	F 8	80			
	document review, it w facility staff failed to n	n, staff interview and facility vas determined that the naintain a bedpan in a clean for one of 30 residents in the lent #35.		 The bedpan in Room 201 Resident #35 was replaced, lab bagged. Any resident has the potential 	peled and		
	The findings include:	ade of Resident #35 on		affected. A 100% audit during rounds will be conducted to ve personal belongings are labele bagged per facility policy.	rify all		
	 1/17/23 at 11:36 AM, at 11:49 AM, 1/18/23 8:38 AM. In the resid bedpan, unlabeled (w for their roommate), a on the floor. On 1/18/23 at 4:22 Pl conducted with LPN # Nurse). She stated th using the bedpan upo after surgery a couple it sometimes. On 1/19/23 at 10:00 A conducted with LPN # Nurse). She stated th plastic bag in the bath labeled. She stated to a plastic bag, is not s 	1/17/23 at 2:30 PM, 1/18/23 at 3:51 PM, and 1/19/23 at lent's bathroom was a whether for Resident #35 or and unbagged, sitting directly M, an interview was #4 (Licensed Practical hat Resident #35 started on return from a hospital visit e months prior, and still used		 3) The Infection Control Nurse designee will educate 100% st ensuring infection prevention a measures to prevent potential infection from personal belong. Education will be included in more orientation. 4) The Infection Control Nurse designee will conduct random control rounds weekly x 4 week monthly 2 months. The DON o will review the audit findings ar the QAPI committee for further recommendations monthly x 3 	aff on nd control spread of ngs. ew hire e or infection ks then r designee nd report to review and		
	that was provided, wa documented, "To ens performed after reside and prevent infections will be performed after	/ policy "Bedpan Cleaning" as conducted. This policy ure that cleaning is ent bed pan use to reduce s. The following procedure er resident bed pan use7. d bedpan with plastic bag or					

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		ID HUMAN SERVICES				FORM	APPROVED
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495401	B. WING				C 19/2023
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 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 880	(the Administrator) ar Nursing) were made	a 77 imately 10:30 AM, ASM #1 ad ASM #2 (the Director of aware of the findings. No as provided by the end of the	F	880			

Facility ID: VA0402

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