

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Tyler's Retreat at Iron Bridge		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 Iron Bridge Rd Chester, VA 23831	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement hospital transfer requirements for two of 36 residents in the survey sample, Residents #96 and #5. The findings include: 1. For Resident #96 (R96), the facility staff failed to provide a bed hold notice when the resident transferred to the hospital on [DATE].</p> <p>A review of R96's clinical record revealed a nurse's note dated 12/27/24 that documented, MD (Medical Doctor) made this nurse aware of need to send resident to ER for evaluation of right jaw swelling. Resident noted to have increased edema of right jaw and MD concerned re: cellulitis or an abscess. Further review of R96's clinical record failed to reveal the resident/resident representative was provided a written notice of the bed hold policy.</p> <p>On 8/12/25 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated a copy of the bed hold policy is supposed to go with the resident when a resident is sent to the hospital and the nurse should document a note this was done.</p> <p>On 8/12/25 at 4:49 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.</p> <p>The facility policy titled, Resident Discharge/Transfer Letter Policy documented, G) The resident or responsible party will receive a bed hold notice along with the discharge/transfer letter, when applicable.</p> <p>No further information was presented prior to exit.</p> <p>2. For R5, the facility staff failed to evidence that written notification was provided to R5's responsible party in a practicable timeframe for a facility-initiated transfer on 03/03/2025 and on 03/25/2025.</p> <p>On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/05/2025, R5 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the R5 was cognitively intact for making daily decisions.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's nurse's note dated 03/03/2025 at 1:34 p.m., for R5 documented in part, "Resident was received by writer with report of consistent pain to abdomen during the night and nausea (PRN (as needed) Tylenol) administered during 11-7 (11:00 p.m. to 7:00 a.m. shift)). Resident remains consistent with c/o (complaint of) pain during medication administration. Writer notified NP (nurse practitioner) and MD (medical doctor) of resident's discomfort and condition. MD in to assess resident with writer. Findings of tenderness to right abdomen w/o distention. Resident reported last BM (bowel movement) was 3/2/25. MD ordered for resident to be sent to EM (emergency room) for further evaluation. Writer contacted 911 for transport. EMT (emergency medical technician) arrived at facility at 1050am (10:50 a.m.) and transported resident safely from w/c (wheelchair) to stretcher by only contact assist (assistance) . The resident's needs cannot be meet [sic] at the facility at this time after several attempts to meet resident's needs. Resident was oriented and prepared for transfer."</p> <p>The facility's nurse's note dated 03/25/25 documented in part, "Pt (patient) left via (by) EMS (emergency medical services) at 1155 (11:55 a.m.) for worsening right upper quadrant pain unrelieved by pain meds"</p> <p>Review of the clinical record and the EHR (electronic health record) for R5 failed to evidence written notification of the discharge was provided to R5's responsible party for the facility-initiated transfers on 03/03/2025 and on 03/25/2025.</p> <p>On 08/12/2025 at approximately 11:45 a.m., a request was made to ASM (administrative staff member) #1, administrator, for evidence that the facility provided R5's responsible party written notification of R5's transfers on 03/03/2025 and on 03/25/2025.</p> <p>On 08/12/2025 at approximately 1:00 p.m. OSM (other staff member) #5, social worker, provide the surveyor with copies of two "U. S. Postal Service Certified Mail Receipts" for the written notifications sent to R5's responsible party for the transfers on 03/03/2025 and on 03/25/2025. Further review of the receipts revealed postage dates of 03/20/2025 and 04/01/2025 indicating that the notification letters were sent 17 and seven days following R5's transfers on 03/03/2025 and on 03/25/2025.</p> <p>On 08/12/2025 at approximately 3:41 p.m. an interview was conducted with OSM #5. When asked if the written notifications to R5's responsible party were sent within a practical time frame she stated no. OSM #5 stated that an acceptable time frame to send the written notification to a responsible party would be within 24 hours on a weekday. She further stated if the resident was sent out on a Friday the written notification to the party responsible would be sent the following Monday.</p> <p>On 08/12/2025 at approximately 4:35 p.m. ASM #1, ASM #2, director of nursing, and RN (registered nurse) #1, assistant director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p>		