STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tyler's Retreat at Iron Bridge	12001 Iron Bridge Rd Chester, VA 23831

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement bed rail requirements for four of 36 residents in the survey sample, Residents #6, #100, #101, and #102. The findings include: 1. For Resident #6 (R6), the facility staff failed to assess the resident for risk of entrapment and failed to attempt appropriate alternatives prior to the resident's use of bed rails (grab bars).On 8/11/25 at 12:44 p.m., R6 was observed lying in bed with bilateral grab bars in the upright position.A review of R6's clinical record (including an enabler-restraint observation form dated 7/3/25) failed to reveal documentation that the facility staff assessed the resident for risk of entrapment or attempted appropriate alternatives.On 8/12/25 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the facility staff does not assess residents for risk of entrapment or attempt alternative devices for residents who use grab bars.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.The facility policy titled, Bed Rail Policy documented, 1. The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. 2. If a bed or side rail or bar is used, the facility will: a. Evaluate the potential risks associated with the use of bed rails including the risk of entrapment, prior to bed rail installation. No further information was presented prior to exit.2. For Resident #100 (R100), the facility staff failed to assess the resident for risk of entrapment and failed to attempt appropriate alternatives prior to the resident's use of bed rails (grab bars).On 8/11/25 at 4:05 p.m., R100 was observed lying in bed with bilateral grab bars in the upright position.A review of R100's clinical record (including an enabler-restraint observation form dated 8/6/25) failed to reveal documentation that the facility staff assessed the resident for risk of entrapment or attempted appropriate alternatives.On 8/12/25 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the facility staff does not assess residents for risk of entrapment or attempt alternative devices for residents who use grab bars.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.No further information was presented prior to exit.3. For Resident #101 (R101), the facility staff failed to assess the resident for risk of entrapment and failed to attempt appropriate alternatives prior to the resident's use of bed rails (grab bars).On 8/11/25 at 1:34 p.m., R101 was observed lying in bed with bilateral grab bars in the upright position.A review of R101's clinical record (including an enabler-restraint observation form dated 8/8/25) failed to reveal documentation that the facility staff assessed the resident for risk of entrapment or attempted appropriate alternatives.On 8/12/25 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the facility staff does not assess residents for risk of entrapment or attempt alternative devices for residents who use grab bars.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.No further information was presented prior to exit.4. For Resident #102 (R102), the facility staff failed to assess the resident for risk of entrapment and failed to attempt appropriate alternatives prior to the resident's use of bed (continued on next page)

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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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rails (grab bars).On 8/11/25 at 1:44 p.m., R102 was observed lying in bed with bilateral grab bars in the upright position.A review of R102's clinical record (including an enabler-restraint observation form dated 8/8/25) failed to reveal documentation that the facility staff assessed the resident for risk of entrapment or attempted appropriate alternatives.On 8/12/25 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the facility staff does not assess residents for risk of entrapment or attempt alternative devices for residents who use grab bars.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.No further information was presented prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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]. 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. 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. 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. 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. No further information was presented prior to exit. 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. 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. 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.” (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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…” 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. 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. 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. 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. 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. No further information was provided prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide respiratory care and services for two of 36 residents in the survey sample, Residents #100, and #102. The findings include: 1. For Resident #100 (R100), the facility staff failed to store a nebulizer (1) mask in a sanitary manner.R100's admission minimum data set assessment was not complete. An admission observation form dated 8/6/25 documented R100 was oriented, the resident's memory was intact, and the resident's thinking was clear and organized. A review of R100's physician's order revealed an order dated 8/8/25 for ipratropium-albuterol inhalation solution (2) for nebulization, 0.5mg (milligrams)-3mg (2.5mg base)/ 3ml (milliliters) every six hours times 72 hours for shortness of breath/wheezing.On 8/11/25 at 4:05 p.m., R100 was observed lying in bed. The resident's nebulizer mask was uncovered and was sitting against the nebulizer machine on top of the resident's nightstand. R100 stated she used the nebulizer mask and staff had not provided anything to cover the mask.On 8/12/25 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated a nebulizer mask should be stored in a plastic bag for infection control purposes.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.The facility policy titled, Nebulizer Administration Policy documented, 11. Empty nebulizer cup, rinse with sterile water/sterile saline and air dry. Wipe mask with alcohol wipe and store them in a plastic bag. No further information was presented prior to exit.References:(1) A nebulizer is a small machine that turns liquid medicine into a mist that can be easily inhaled. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm(2) Ipratropium-albuterol inhalation solution is used to relax muscle in the airways and enables better breathing. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm2. For Resident #102 (R102), the facility staff failed to obtain a physician's order for the use of an incentive spirometer and failed to store the incentive spirometer in a sanitary manner. R102's admission minimum data set assessment was not complete. An admission observation form dated 8/8/25 documented R102 was oriented, the resident's memory was intact, and the resident's thinking was clear and organized. A review of R102's clinical record failed to reveal a physician's order for an incentive spirometer.On 8/11/25 at 1:44 p.m., R102 was observed lying in bed. An incentive spirometer was observed sitting on the resident's overbed table, with the mouthpiece uncovered. R102 stated she used the incentive spirometer and staff had not provided a cover for the mouthpiece.On 8/12/25 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated a physician's order should be obtained for an incentive spirometer because the use of the device was a treatment. LPN #1 stated an incentive spirometer should be stored in a plastic bag for infection control purposes.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.The facility policy titled, Incentive Spirometry Policy documented, Licensed clinicians with demonstrated competence may provide incentive spirometry education and therapy as ordered by a provider. EQUIPMENT: 3. Plastic bag for storage. No further information was presented prior to exit.Reference:(1) Your health care provider may recommend that you use an incentive spirometer after surgery or when you have a lung illness, such as pneumonia. The spirometer is a device used to help you keep your lungs healthy. Using the incentive spirometer helps you take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to implement a pain management program consistent with professional standards of practice for one of 36 residents in the survey sample, Resident #63. The findings include:On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 5/2/2025, the resident scored two out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were severely impaired for making daily decisions. It further documented R63 receiving as needed pain medications and not having pain in the past five days.The physician orders for R63 documented in part, Morphine concentrate (1) 100mg(milligram)/5ml(milliliter) (20mg/ml); 0.25ml oral every 4 hours PRN (as needed) pain/SOB (shortness of breath). Before: Pain; Non-Pharm Intervent(s). Start date: 08/27/2024. The orders also documented, Acetaminophen [OTC] (over the counter) (2) tablet extended release 650mg; two tablets oral every 4 hours PRN. Give two tablets by mouth every four hours as needed for pain. Do not exceed 3 grams in 24 hours. Offer non-pharmacological interventions prior to administration. Start Date: 04/29/2024. The physician orders failed to evidence pain level parameters for staff to follow for administration of the medications listed above.Review of the eMAR (electronic medication administration record) for R63 dated 6/1/2025-6/30/2025 documented the Acetaminophen administered once for a pain level of four and the Morphine administered eight times for pain levels between five and seven.Review of the eMAR for R63 dated 7/1/2025-7/31/2025 documented the Acetaminophen administered once for a pain level of five and the Morphine administered once for a pain level of six.Review of the eMAR for R63 dated 8/1/2025-8/30/2025 failed to evidence administration of doses the Acetaminophen or the Morphine.The comprehensive care plan for R63 documented in part, Problem Start Date: 06/19/2024. Category: Pain. Potential for pain related to ischemic cardiomyopathy, reflux, contracture of both pinky fingers, and hiatal hernia - c/o (complaints of) tooth pain; noted caries/chipped teeth/hx of infection. Edited: 05/15/2025 .On 8/12/2025 at 3:05 p.m., an interview was conducted with RN (registered nurse) #3 who stated that R63's pain was assessed using facial expressions, grimacing and behaviors. She stated that there were times when R63 could verbalize pain but not always and staff went by the actions of the resident when administering the as needed pain medications. RN #3 stated that the Morphine and Acetaminophen orders should have pain level parameters in place for staff to use as guidance for administration because they did not want to overmedicate the resident.On 8/12/2025 at 4:08 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that when a resident had multiple pain medications ordered the staff should perform a pain assessment and administer the milder pain medication for mild to moderate pain. She stated that when a resident was cognitively impaired, they went by behaviors and facial expressions to evaluate pain, and she would expect the medication orders to have pain level parameters for staff to use to guide them when to administer each medication. The facility policy Pain Management Policy revised 1/8/2025 documented in part, .If non-pharmacological intervention[s] fail[s] then when multiple PRN medications are available with corresponding intensity ratings, the resident will be administered the medication ordered for the corresponding pain rating within the PRN order .According to Fundamentals of Nursing, eighth edition, 2013, [NAME] & [NAME] page 977 documented in part, .Pain therapy requires an individualized approach, perhaps more so than any other patient problem. The nurse, patient, and frequently the family are partners in pain management. Nurses administer and monitor interventions ordered by health care providers for pain relief in addition to complimentary pain-relief measures. Usually, you try the least invasive or safest therapy first along with previously used successful patient remedies. If there is a question about a medical therapy, consult with the health care provider.On 8/12/2025 at 4:35 p.m., ASM #1, the administrator and ASM #2, the director of (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing were made aware of the concern.No further information was provided prior to exit.Reference:(1) Morphine immediate-release tablets and oral solution are used to relieve severe, acute pain (pain that begins suddenly, has a specific cause, and is expected to go away when the cause of the pain is healed) and chronic pain in people who are expected to need an opioid pain medication and who cannot be treated with other pain medications. Morphine extended-release tablets and capsules are used to relieve severe and persistent pain in people who are expected to need an opioid pain medication around the clock and who cannot be treated with other pain medications. Morphine extended-release tablets and capsules should not be used to treat pain that can be controlled by medication that is taken as needed. Morphine is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain . This information was obtained from the website: Morphine: MedlinePlus Drug Information (2) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body . This information was obtained from the website: Acetaminophen: MedlinePlus Drug Information