

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

PRINTED: 08/13/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/12/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>SKYVIEW SPRINGS REHAB AND NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 MONTVUE DRIVE</b> <b>LURAY, VA 22835</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{E 000}	Initial Comments  An unannounced Medicare/Medicaid second revisit to the abbreviated COVID-19 Focused Infection Control survey conducted 4/29/20 through 5/11/20 and first revisit survey conducted 7/21/20 through 7/22/20, was conducted on 8/12/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	{E 000}			
{F 000}	INITIAL COMMENTS  An unannounced Medicare/Medicaid second revisit to the abbreviated COVID-19 Focused Infection Control survey conducted 4/29/20 through 5/11/20 and first revisit survey conducted 7/21/20 through 7/22/20, was conducted on 8/12/20. The facility was in substantial compliance with 42 CFR Part 483 Federal Long Term Care Requirements.  The census in this 120 certified bed facility was 104 at the time of the survey. The survey sample consisted of three current resident reviews (Residents #201 through 203).	{F 000}			

**RECEIVED**  
**AUG 18 2020**  
**VDH/OLC**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Pamela Jill L. Seby, RN, LNHA*

*Administrator*

*8/14/2020*

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.