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

PRINTED: 11/15/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SKYLINE NURSING & REHABILITATION CENTER  SKYLINE NURSING & REHABILITATION CENTER  SKYLINE NURSING & REHABILITATION CENTER  (EACH DEPICION MISST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  (E 000) Initial Comments  N/A  (F 000) Initial Comments  An offsite revisit survey was conducted on 11/15/22 for all previous deficiencies cited on 9/22/22. All deficiencies have been corrected. The facility is in compliance with all regulations surveyed.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  SKYLINE NURSING & REHABILITATION CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (F 000)  (F 000)  An offsite revisit survey was conducted on 11/15/22 for all previous deficiencies cited on 9/22/22. All deficiencies have been corrected. The facility is in compliance with all regulations			495348	B. WING		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (E 000)  Initial Comments  (F 000)  INITIAL COMMENTS  An offsite revisit survey was conducted on 11/15/22 for all previous deficiencies cited on 9/22/22. All deficiencies have been corrected. The facility is in compliance with all regulations  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLETIC DATE  COMPLETIC DATE					237 FRANKLIN PIKE ROAD, SE	1 11/10/2022
N/A  {F 000}  INITIAL COMMENTS  An offsite revisit survey was conducted on 11/15/22 for all previous deficiencies cited on 9/22/22. All deficiencies have been corrected. The facility is in compliance with all regulations	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
{F 000} INITIAL COMMENTS {F 000}  An offsite revisit survey was conducted on 11/15/22 for all previous deficiencies cited on 9/22/22. All deficiencies have been corrected. The facility is in compliance with all regulations	{E 000}	Initial Comments		{E 000	}	
11/15/22 for all previous deficiencies cited on 9/22/22. All deficiencies have been corrected. The facility is in compliance with all regulations	{F 000}		8	{F 000	}	
		11/15/22 for all previous 9/22/22. All deficient The facility is in comp	ous deficiencies cited on cies have been corrected.			

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

10/06/2022

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.