STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E075	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE TERRACE CONV HOME	123 LAKEVIEW ROAD WOODSTOCK, VA 22664

(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 Emergency Preparedness survey was conducted 1/30/2023 through 1/31/2023. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the	E 022		2/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/07/2023

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E 022	Continued From page 1 following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The findings include: Facility staff failed to develop policies and procedures of how the facility will utilize volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. An interview was conducted on 1/31/2023 at 12:07 p.m. with ASM (administrative staff member) #3, the compliance officer. When the policy was reviewed ASM #3 stated she did not have it in her plan how to utilize volunteers in the event of an emergency. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3 were made aware of the above concerns on 1/31/2023 at 2:20 p.m. No further information was obtained prior to exit.	E 022	1. The Administrator or designee will develop policies and procedures of how the facility will utilize volunteers who remain in the facility and will implement in the facility's emergency plan. 2. All residents have the potential to be affected by the deficient practice. 3. Facility staff will be re-educated to the emergency plan to ensure the deficient practice does not reoccur. 4. The Administrator or designee will update the emergency plan, re-educate staff to the plan, and review the plan annually to ensure that solutions are maintained. 5. The corrective action will be accomplished by February 24, 2023. Results will be reported to the QA committee. Findings and results will be reflected in the QA minutes.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.542(b)(5), §485.625(b)(5),	E 023		2/24/23

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E 023	Continued From page 2 §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b) and REHs at §485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	E 023	1. The Administrator or designee will	

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E 023	Continued From page 3 review it was determined that the facility staff failed to have a complete emergency preparedness plan to include confidentiality of resident information. The findings include: Facility staff failed to develop policies and procedures of how the facility plans to protect the confidentiality of patient/resident information. On 1/31/2023 at 12:07 p.m. a review of the facility's emergency preparedness plan was conducted with ASM (administration staff member) #3, the compliance officer. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures of how the facility plans to preserve patient information and protect the confidentiality of patient information. When asked about the plan, ASM # 3 stated, "I feel we need more information regarding resident records; can't find anything that specifically states about the confidentiality of the medical records." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3 were made aware of the above concerns on 1/31/2023 at 2:20 p.m. No further information was obtained prior to exit.	E 023	develop policies and procedures of how the facility will protect the confidentiality of patient/resident information and will implement in the facility's emergency plan. 2. All residents have the potential to be affected by the deficient practice. 3. Facility staff will be re-educated to the emergency plan to ensure the deficient practice does not reoccur. 4. The Administrator or designee will update the emergency plan, re-educate staff to the plan, and review the plan annually to ensure that solutions are maintained. 5. The corrective action will be accomplished by February 24, 2023. Results will be reported to the QA committee. Findings and results will be reflected in the QA minutes.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2),	E 031		2/24/23

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E 031	Continued From page 4 §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan for communication. The findings include:	E 031	1. Required Emergency Officials contact information was added in the facility's emergency plan on 1/31/2023. 2. All residents have the potential to be affected by the deficient practice. 3. Facility staff will be re-educated to the	

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E 031	Continued From page 5 Facility staff failed to document that all required Emergency Officials contact information were included in the communication plan. On 1/31/2023 at 12:07 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administration staff member) #3, the compliance officer. Review of the facility's emergency preparedness plan failed to evidence documentation that all required Emergency Officials contacts are included in the communication plan. ASM #3 stated, "I just created the list, it wasn't in the book." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3 were made aware of the above concerns on 1/31/2023 at 2:20 p.m. No further information was obtained prior to exit.	E 031	emergency plan to ensure the deficient practice does not reoccur. 4. The Administrator or designee will update the emergency plan, re-educate staff to the plan, and review the plan annually to ensure that solutions are maintained. 5. The corrective action will be accomplished by February 24, 2023. Results will be reported to the QA committee. Findings and results will be reflected in the QA minutes.	
F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted 01/30/2023 through 01/31/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 70 bed certified facility was 51 at the time of the survey. The survey sample consisted of 14 current resident reviews and two closed record reviews.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		2/24/23

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Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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F 623	Continued From page 8 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide written notice of a hospital transfer to the resident and/or resident representative and the Office of the State Long-Term Care Ombudsman for one of 16 residents in the survey sample; Resident #26. The findings include: Resident #26 was transferred to the hospital on 12/7/22, however notice of the hospital transfer was not provided to the resident and/or resident representative or the ombudsman. A review of the clinical record revealed a nurse's note dated 12/7/22 that documented, "Resident was observed to be lying on the floor face down right beside [their] bed...POA (power of attorney) called and updated. Resident was sent to ER (emergency room) for imagining since resident hit [their] head and [they are] is on blood thinners. MD (medical doctor) aware. Report called to ER	F 623	1. The DON or designee will notify the resident representative and the ombudsman in writing of the hospital transfer for Resident #26. 2. The DON or designee will review facility discharges and transfers from the last 30 days to ensure that all responsible parties and the ombudsman were notified of the transfer or discharge in writing. 3. Licensed Nurses will be re-educated on providing written notice of a transfer or discharge to the resident's responsible party and to the ombudsman. 4. The DON or designee will review all facility discharges and transfers weekly for 4 weeks to ensure that all responsible parties and the ombudsman were notified of the transfer or discharge in writing. 5. The corrective action will be accomplished by February 24, 2023. Results will be reported to the QA committee. Findings and results will be reflected in the QA minutes.	

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nurse, [name]."

This note and further review of the clinical record failed to evidence that a written notice of a hospital transfer was provided to the resident and/or representative or the ombudsman of the hospital transfer.

A "Transfer/Discharge Resident" form, dated 12/7/22 was reviewed. This document failed to evidence that a written notice of a hospital transfer was provided to the resident representative and ombudsman of the above hospital transfer.

On 1/31/23 at approximately 2:15 PM, in an interview with ASM #1 (Administrator Staff Member) the Administrator, he stated that the written notices were not provided because the resident returned to the facility and was not admitted to the hospital.

A review of the facility policy, "Transfer/Discharge Policy" did not include any direction for providing written notification to the resident representative and ombudsman of a hospital transfer.

No further information was provided by the end of the survey.