	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
49E075		B. WING		01/31/2023			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SKYLINE 1	FERRACE CONV HOME			123 LAKEVIEW ROAD WOODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO		
E 000	Initial Comments		E 000				
	survey was conducted 1/31/2023. Correction compliance with 42 C Requirement for Long emergency prepared	ns are required for FR Part 483.73, g-Term Care Facilities. No ness complaints were					
I	investigated during th Policies/Procedures f CFR(s): 483.73(b)(4)	-	E 022	2	2/24/23		
	§441.184(b)(4), §460 §483.73(b)(4), §483.4 §485.542(b)(4), §485	.54(b)(3), §418.113(b)(6)(i), .84(b)(5), §482.15(b)(4), 475(b)(4), §485.68(b)(2), .625(b)(4), §485.727(b)(2), .12(b)(2), §494.62(b)(3).					
	develop and impleme policies and procedur plan set forth in parage assessment at parage and the communication this section. The poli- be reviewed and update	edures. The [facilities] must int emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years lities]. At a minimum, the es must address the					
		A means to shelter in place I volunteers who remain in					
	and procedures. (6) The following are	es at §418.113(b):] Policies additional requirements for atient care facilities only.					
		edures must address the					

**Electronically Signed** 

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.

02/07/2023

PRINTED: 02/07/2023

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/07/2023 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			01/31/2023		
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
SKYLINE TERRACE CONV HOME				12	23 LAKEVIEW ROAD			
				W	OODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 022	This REQUIREMENT by: Based on staff intervi- review it was determin failed to have a comp preparedness plan. The findings include: Facility staff failed to oprocedures of how the volunteers who remai those policies and pro- the facility's emergence management. An interview was comp 12:07 p.m. with ASM member) #3, the com- policy was reviewed A have it in her plan how event of an emergence ASM #1, the administ	in place for patients, ho remain in the hospice. is not met as evidenced ew and facility document hed that the facility staff lete emergency develop policies and e facility will utilize n in the facility and how bocedures are aligned with cy plan and risk ducted on 1/31/2023 at (administrative staff pliance officer. When the NSM #3 stated she did not w to utilize volunteers in the cy.	E	022	<ol> <li>The Administrator or designee w develop policies and procedures of h the facility will utilize volunteers who remain in the facility and will implement the facility's emergency plan.</li> <li>All residents have the potential to affected by the deficient practice.</li> <li>Facility staff will be re-educated emergency plan to ensure the deficient practice does not reoccur.</li> <li>The Administrator or designee w update the emergency plan, re-educated staff to the plan, and review the plan annually to ensure that solutions are maintained.</li> <li>The corrective action will be accomplished by February 24, 2023. Results will be reported to the QA committee. Findings and results will the reflected in the QA minutes.</li> </ol>	ow nt in o be o the nt II te		
E 023 SS=C	Policies/Procedures for CFR(s): 483.73(b)(5) §403.748(b)(5), §416 §441.184(b)(5), §460 §483.73(b)(5), §483.4	was obtained prior to exit. or Medical Documentation 6.54(b)(4), §418.113(b)(3), .84(b)(6), §482.15(b)(5), .75(b)(5), §484.102(b)(4), .42(b)(5), §485.625(b)(5),	EC	023			2/24/23	
	3.00.00(0)(0), 3+00.0							

Facility ID: VA0226

If continuation sheet Page 2 of 10

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/07/2023	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMPI		
		49E075	B. WING		_	01/31/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
SKYLINE TERRACE CONV HOME				123 LAKEVIEW ROAD WOODSTOCK, VA 2260	84			
0(1)15	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			-	S PLAN OF CORRECTION		(2/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 023	Continued From page	2	E 023	3				
		.920(b)(4), §486.360(b)(2),						
	develop and impleme policies and procedur plan set forth in parag assessment at paragr and the communication this section. The policies ereviewed and upda [annually for LTC facili policies and procedur following:] [(5) or (3),(4),(6)] A sy documentation that pri- protects confidentiality secures and maintain *[For RNHCIs at §403 §485.542(b):] Policies system of care docum following: (i) Preserves patient i (ii) Protects confidentiality	vstem of medical reserves patient information, y of patient information, and s availability of records. 8.748(b) and REHs at and procedures. (5) A mentation that does the information. iality of patient information. ntains the availability of						
	procedures. (2) A sys documentation that pr donor information, pro potential and actual d secures and maintain This REQUIREMENT	stem of medical reserves potential and actual otects confidentiality of						
	by: Based on staff intervi	iew and facility document		1. The Administr	ator or designee will			

Facility ID: VA0226

If continuation sheet Page 3 of 10

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 49E075 B. WING 01/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **123 LAKEVIEW ROAD** SKYLINE TERRACE CONV HOME WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 023 Continued From page 3 E 023 review it was determined that the facility staff develop policies and procedures of how failed to have a complete emergency the facility will protect the confidentiality of preparedness plan to include confidentiality of patient/resident information and will resident information. implement in the facility's emergency plan. 2. All residents have the potential to be The findings include: affected by the deficient practice. Facility staff will be re-educated to the 3. Facility staff failed to develop policies and emergency plan to ensure the deficient procedures of how the facility plans to protect the practice does not reoccur. confidentiality of patient/resident information. 4. The Administrator or designee will update the emergency plan, re-educate On 1/31/2023 at 12:07 p.m. a review of the staff to the plan, and review the plan facility's emergency preparedness plan was annually to ensure that solutions are conducted with ASM (administration staff maintained. member) #3, the compliance officer. Review of 5. The corrective action will be the facility's emergency preparedness plan failed accomplished by February 24, 2023. to evidence documentation of policies and Results will be reported to the QA procedures of how the facility plans to preserve committee. Findings and results will be patient information and protect the confidentiality reflected in the QA minutes. 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 031 **Emergency Officials Contact Information** E 031 2/24/23 SS=C 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),

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0226

If continuation sheet Page 4 of 10

PRINTED: 02/07/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 02/07/2023 MAPPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE		
		49E075	B. WING		01/	31/2023
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1:	23 LAKEVIEW ROAD		
SKYLINE TERRACE CONV HOME			v	VOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 031	Continued From page §491.12(c)(2), §494.6 [(c) The [facility] must		E 031			
	emergency preparedr that complies with Fe	ness communication plan deral, State and local laws d and updated at least every LTC facilities]. The				
	<ul> <li>(2) Contact informatio</li> <li>(i) Federal, State, triba</li> <li>emergency preparedri</li> <li>(ii) Other sources of a</li> </ul>	al, regional, and local ness staff.				
	information for the foll (i) Federal, State, trib emergency preparedr (ii) The State Licensin	al, regional, and local ness staff. ng and Certification Agency. State Long-Term Care				
	(iv) The State Protect This REQUIREMENT by:	lowing: al, regional, and local ness staff.		1. Required Emergency Officials c		
	review it was determin failed to have a comp preparedness plan for The findings include:			<ul> <li>information was added in the facility' emergency plan on 1/31/2023.</li> <li>All residents have the potential faffected by the deficient practice.</li> <li>Facility staff will be re-educated</li> </ul>	o be	

Event ID: KNVD11

Facility ID: VA0226

If continuation sheet Page 5 of 10

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 49E075 B. WING 01/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **123 LAKEVIEW ROAD** SKYLINE TERRACE CONV HOME WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 031 Continued From page 5 E 031 emergency plan to ensure the deficient Facility staff failed to document that all required practice does not reoccur. Emergency Officials contact information were 4. The Administrator or designee will included in the communication plan. update the emergency plan, re-educate staff to the plan, and review the plan On 1/31/2023 at 12:07 p.m. a review and annually to ensure that solutions are interview of the facility's emergency preparedness maintained. plan was conducted with ASM (administration 5 The corrective action will be staff member) #3, the compliance officer. Review accomplished by February 24, 2023. of the facility's emergency preparedness plan Results will be reported to the QA failed to evidence documentation that all required committee. Findings and results will be Emergency Officials contacts are included in the reflected in the QA minutes. 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. F 000 **INITIAL COMMENTS** F 000 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 623 Notice Requirements Before Transfer/Discharge F 623 2/24/23 CFR(s): 483.15(c)(3)-(6)(8) SS=D §483.15(c)(3) Notice before transfer.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0226

If continuation sheet Page 6 of 10

PRINTED: 02/07/2023

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 02/07/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
49E075			B. WING			01/31/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYLINE TERRACE CONV HOME					123 LAKEVIEW ROAD WOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and mannel facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(f (D) An immediate tran required by the reside under paragraph (c)(f	fers or discharges a hust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The boy of the notice to a Office of the State budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or hder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	623			

Facility ID: VA0226

If continuation sheet Page 7 of 10

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/07/2023 APPROVED 0: 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			01/31/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
SKYLINE TERRACE CONV HOME				123 LAKEVIEW ROAD				
				WOODSTOCK, VA 2260	64			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From page	7	F 623	8				
	notice specified in par must include the follow (i) The reason for tran (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of the Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of the protection and adv developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilitt disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individua §483.15(c)(6) Change If the information in the	nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how rm and assistance in nd submitting the appeal s (mailing and email) and the Office of the State budsman; v residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with ities established under Part cal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental nabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act.						

If continuation sheet Page 8 of 10

## **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 49E075 B. WING 01/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **123 LAKEVIEW ROAD** SKYLINE TERRACE CONV HOME WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 623 Continued From page 8 F 623 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(I). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review 1. The DON or designee will notify the and facility document review, it was determined resident representative and the that the facility staff failed to provide written notice ombudsman in writing of the hospital of a hospital transfer to the resident and/or transfer for Resident #26. resident representative and the Office of the State 2. The DON or designee will review Long-Term Care Ombudsman for one of 16 facility discharges and transfers from the residents in the survey sample; Resident #26. last 30 days to ensure that all responsible parties and the ombudsman were notified The findings include: of the transfer or discharge in writing. 3. Licensed Nurses will be re-educated Resident #26 was transferred to the hospital on on providing written notice of a transfer or 12/7/22, however notice of the hospital transfer discharge to the resident's responsible was not provided to the resident and/or resident party and to the ombudsman. representative or the ombudsman. 4. The DON or designee will review all facility discharges and transfers weekly A review of the clinical record revealed a nurse's for 4 weeks to ensure that all responsible note dated 12/7/22 that documented, "Resident parties and the ombudsman were notified was observed to be lying on the floor face down of the transfer or discharge in writing. right beside [their] bed...POA (power of attorney) 5 The corrective action will be called and updated. Resident was sent to ER accomplished by February 24, 2023. (emergency room) for imagining since resident hit Results will be reported to the QA [their] head and [they are] is on blood thinners. committee. Findings and results will be MD (medical doctor) aware. Report called to ER reflected in the QA minutes.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0226

PRINTED: 02/07/2023 FORM APPROVED

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/07/2023 APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49E075	B. WING			_	01/31/2023		
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
SKYLINE TERRACE CONV HOME					23 LAKEVIEW ROAD VOODSTOCK, VA 2266	4			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA BEFICIENCY)		(X5) COMPLETION DATE	
F 623	failed to evidence that hospital transfer was and/or representative hospital transfer. A "Transfer/Discharge 12/7/22 was reviewed evidence that a writte transfer was provided representative and on hospital transfer. On 1/31/23 at approxi interview with ASM #7 Member) the Administ written notices were m resident returned to the admitted to the hospit A review of the facility Policy" did not include	review of the clinical record t a written notice of a provided to the resident or the ombudsman of the e Resident" form, dated I. This document failed to n notice of a hospital to the resident nbudsman of the above imately 2:15 PM, in an I (Administrator Staff trator, he stated that the not provided because the ne facility and was not al.	F	623					
	No further information the survey.	was provided by the end of							

Facility ID: VA0226

If continuation sheet Page 10 of 10