STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0243	A. BUILDING: _____ B. WING _____	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE PRESBYTERIAN RETIREMENT C(	3935 SUNNYSIDE DRIVE, SUITE A HARRISONBURG, VA 22801

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 02/07/2023 through 02/09/2023. The facility was not in compliance with the Virginia Regulations for the Licensure of Nursing Facilities. The census in this 84 certified bed facility was 68 at the time of the survey. The survey sample consisted of Sixteen (16) current Resident reviews and two (2) closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-140 Policies and Procedures (E-3a.) Cross reference to F607 12 VAC 5-371-360 Clinical Records (E-6) Cross Reference to F645	F 001	12 VAC 5-371-140 Policies and Procedures Please accept the Plan of Correction Steps I-V referenced in tag F607 12 VAC 5-371-360 Clinical Records Please accept the Plan of Correction Steps I-V referenced in tag F645	3/6/23

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

Electronically Signed | 02/27/23